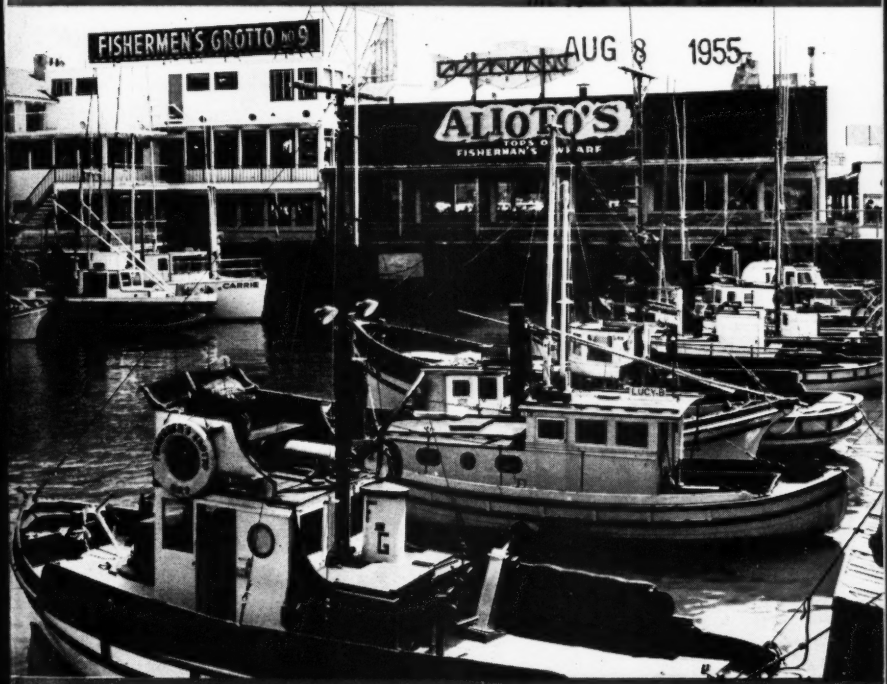
Oral Hygiene

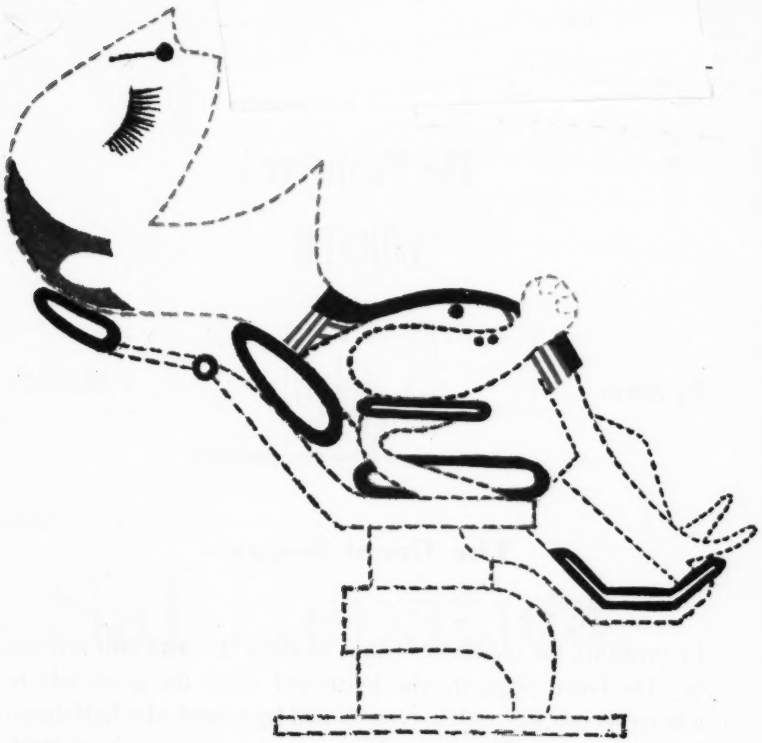
AUGUST 1955



Fisherman's Wharf, San Francisco, California. The American Dental Association will hold its 96th annual session in San Francisco, October 17 to 20.

In this issue:

FLIGHT INTO ANESTHETIC SLEEP



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The Publisher's CORNER

By Mass

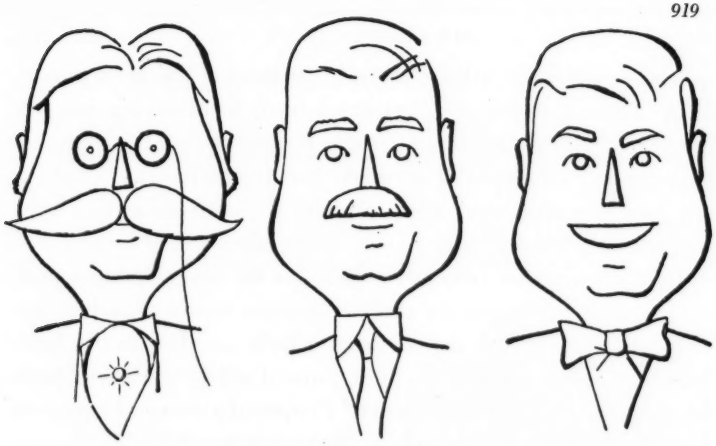
No. 409

The Great Sequaw

IN IRELAND, the old-timers (some of them at least) still remember The Great Sequaw, who journeyed about the green isle in a horse-drawn wagonette accompanied by a band of a half-dozen instrumentalists. The Great Sequaw was an American, a physician and a dentist—or so he claimed to be—and the wagonette and the band, like the big broad-brimmed hat he wore, were part of his act.

A while ago, James Redington wrote about The Great Sequaw in an Irish newspaper, *The Connacht Tribune*, the home-town paper of an old friend of this department, Tom Glynn of Chicago, who sends along a clipping of the Sequaw story.

James Redington remembers that The Great Sequaw erected a canvas shelter on Eyre Square, Galway, where "he used to minister to his patients—and they were many, just as they were many in every area where he practiced." The "doctor" had a



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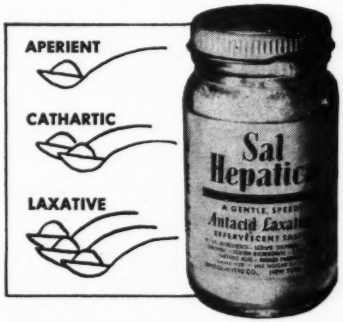

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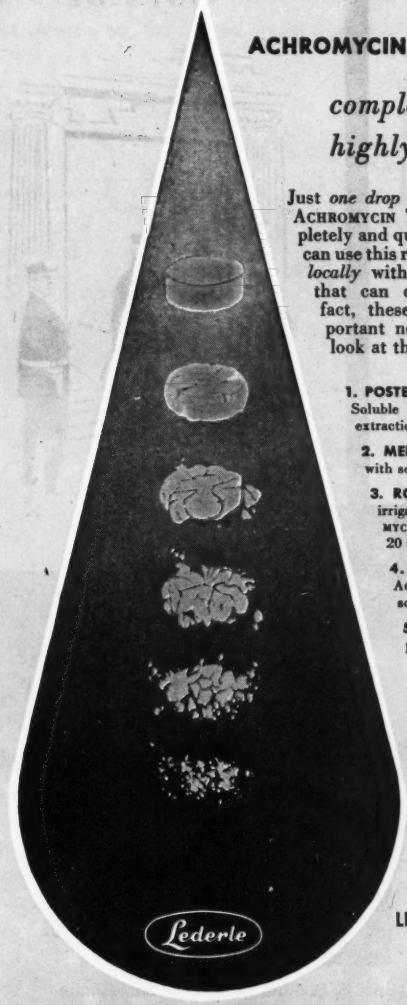
special welcome for folks afflicted by toothache. The band played on as The Great Sequaw "extracted teeth from aching jaws in the presence of an admiring crowd. It may be that the vigorous performance of the band drowned twinges of pain . . . but, in any case, the spectators were left with the impression that here was not only a good show but an outstanding practitioner . . ."

James Redington remembers that "as the dental patient took his place in the temporary shelter, Sequaw would examine him with an electric beam thrown from a bulb attached to his forehead and, turning to the spectators, would tell them: 'I will pave the Square of Galway with ivory.' Frequently, he would remind them, in the words of his slogan: 'Sequaw never fails.' "

And, as the old song goes, "The band played on." It may not have been fun for the patient, but it was fun for the crowd who loved the colorful spectacle, and the entertainment provided by "a man of magnetic personality and outstanding showmanship," according to Redington's description.

Sequaw was not only a physician and a dentist—or claimed to be—but he was also in the pharmaceutical business. He sold Sequaw's Prairie Flower and Sequaw's Oil, lotions for toothaches, rheumatism, and lumbago. Between his medical and dental practice and the lotion sideline, they say that Sequaw became a wealthy man, notwithstanding the cost of that band, and hay or something for the nags.

The Great Sequaw had rivals, of course. One was called Cummings. He sold toothache powder as a sideline along with a powder to sharpen razors. Cummings demonstrated it in Eyre Square using in the demonstration a hair plucked from his head, drawing the sharpened razor across the hair as he shouted, "It would shave a cat asleep, a mouse awake, or a man without soap or water!" Like so many of us, he highly recommended his own handiwork.



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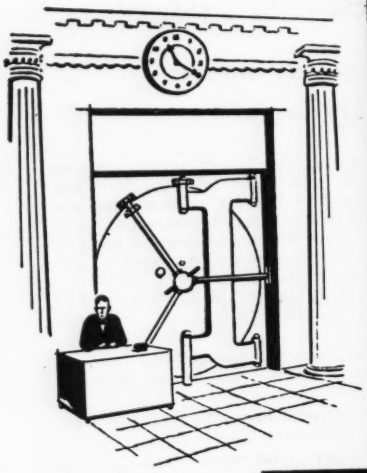

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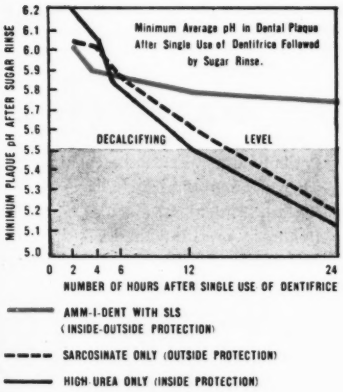

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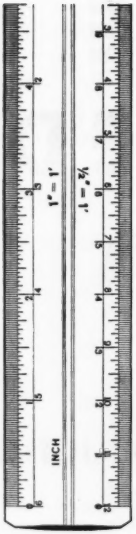

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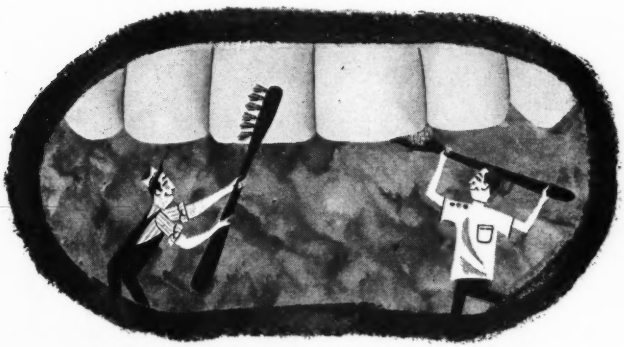

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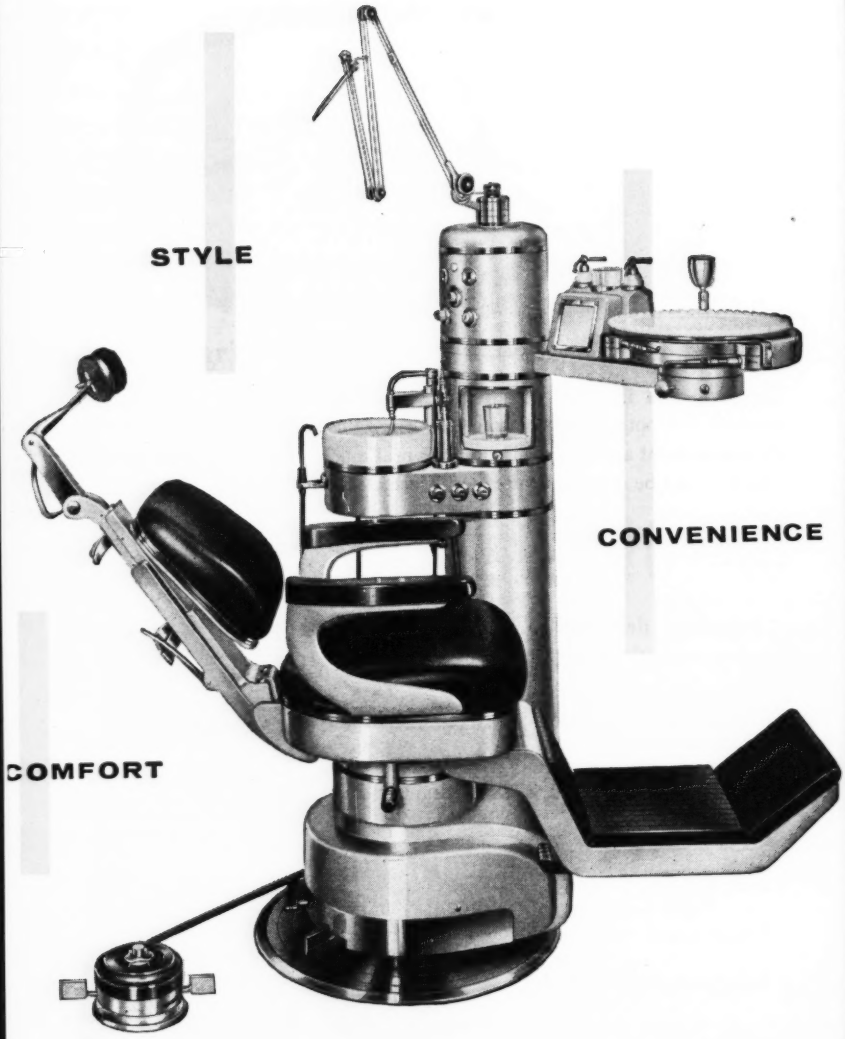
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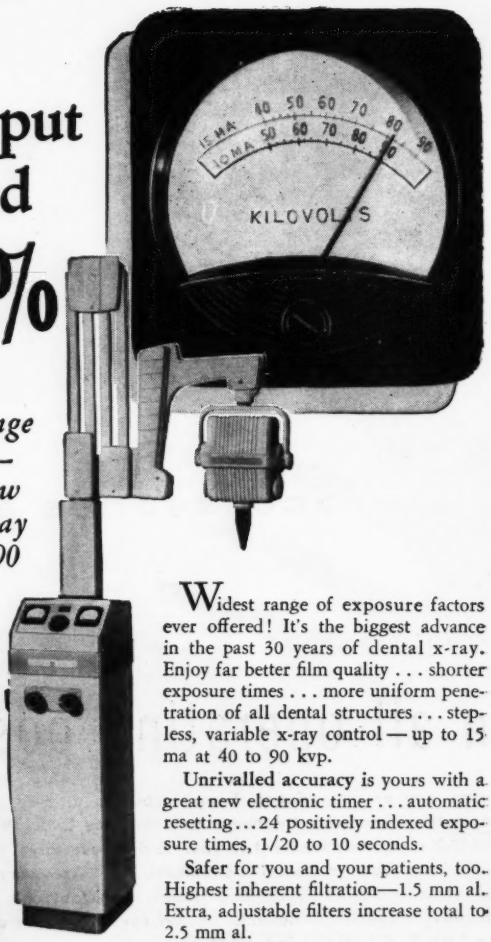

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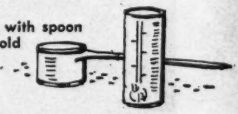

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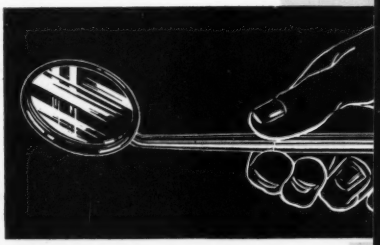

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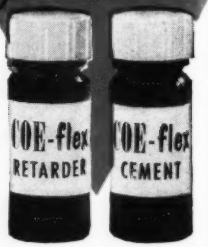

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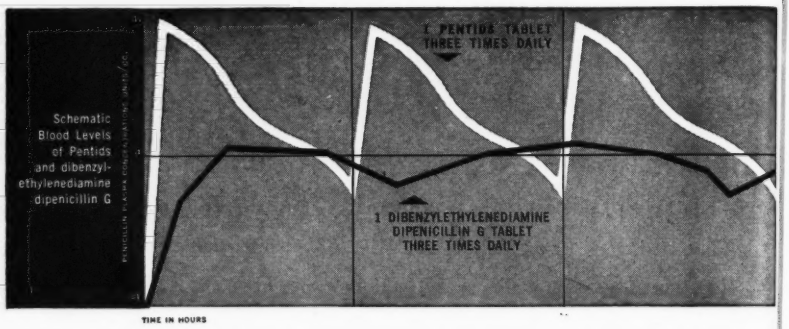

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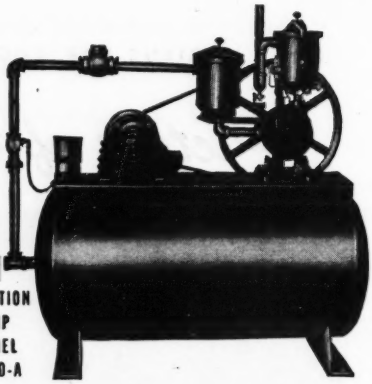
Picture of the Month

KEVIN W. TOAL, 29, who received his doctor of dental surgery degree from the St. Louis University School of Dentistry, is shown on graduation day with his wife and seven children. Doctor Toal worked at part-time jobs to support his large family while attending dental school for six years. Pictured are: First row (left to right) Bridget 2, Kathleen 8 months, Maureen 3; Second row: Doctor and Mrs. Toal and Timothy 4; Third row: Cheryl 8, Kevin 9, and Patrick 5.—*Photograph by George T. Oshiro, St. Louis University School of Dentistry.*

Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*

central suction



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FLIGHT

into Anesthetic Sleep

BY ALLAN J. WINTNER, D.D.S.

The author discusses the degree of patient comfort to be desired and the value of anesthetics in attaining it.

PROPER dental treatment takes time, costs money, and is generally attended by some degree of discomfort. The average dental patient seeks freedom from pain, moderate fees, and a speedy completion of his case. Over the years, dentistry has developed techniques to counteract adverse reactions to dental treatment. The use of anesthetics, high-speed engines, diamond, and air-abrasive instruments, are a few of these methods. It is often possible to reduce the time element, which seems to disturb so many patients. Discomfort can be minimized and pain virtually eliminated. Unfortunately, we seem to progress slowly in overcoming the cost factor—a fault we share with many segments of the economy. This article offers no solution to the cost problem. It does question the matter of patient comfort and the use of anesthesia in dentistry.

In discussing means of increasing patient comfort, the current trend toward general anesthesia should be considered. No practitioner would question the proper use of general anesthesia in dentistry. The profession, which is responsible for the discovery and much of the development of these agents, is rightfully proud of its part in overcoming fear and pain. Properly employed and administered, general anesthetics are an essential part of dental practice. The question arises as to whether the use of these anesthetics in general practice is being overextended and abused.

Dentistry is also entitled to much credit for the development and use of local anesthesia. Dentists and their patients tend to deprecate the skill and knowledge required in the use of local anesthetics for operative and surgical treatment. The variety and extent

of the operations performed in the average dental office under local anesthesia are truly amazing. We underestimate this vital aid to dental practice only because of constant accessibility.

The use of local anesthesia is not conducive to a volume practice. Proper cavity preparation and tooth restoration require considerable time; local anesthetics will not shorten this time sufficiently to meet the requirements of many of today's practices. It is difficult to argue with success—and even more difficult to question the sizable financial returns from multiple cavity preparations made possible by the use of general anesthetics. Many dentists have completed the treatment of a child in one visit by using sodium pentothal®. This is an alluring prospect to many of us who must treat the frightened or intractable child, although it is a temptation we would be wise to resist.

The quality of the operative treatment accomplished under general anesthesia is an important consideration, but one I am not prepared to discuss. Conversations with men using this technique lead me to question seriously the nature of the treatment, but I cannot evaluate it from personal experience. The discussion, therefore, becomes a rather tenuous one of desirability and professional responsibility.

I have used local anesthesia with satisfactory results on patients ranging in age from five to ninety-four full years. This includes a sizable number of mandibular injections administered to six, seven, and eight-year-old children. Such use of local anesthesia is duplicated in many dental offices daily. The practice is not an easy one, and the financial rewards are not overwhelming. Nevertheless, it can be done and, I believe, it should be done.

The flight into sleep for dental treatment seems to me, in many cases, a shirking of responsibility on the part of the patient as well as the dentist. Many of life's experiences are trying and uncomfortable, and the desire for complete anesthesia (alcoholism, sedation, escape neuroses) all too familiar. I believe we do a disservice in pandering to this trend.

The dentist should arm himself with the weapons needed to combat the dread of dental treatment. These weapons are psychologic as well as pharmaceutic. The temporary advantage gained by restoring a child's teeth under general anesthesia might well be examined in the light of its cumulative effect. This applies with immeasurable emphasis to the immature adult who will resist treatment unless a general anesthetic is used. Dentists may use premedication, local anesthetics, and many other methods, to make dental treatment less uncomfortable and more tolerable. We cannot pretend to make the treatment completely pleasant; but even life itself is not always a solicitous respector of tender feelings and emotions. Eventually our pa-

tients must face many hard realities, and, in perspective, the adjustment to dental treatment is microscopic in importance.

Risk Involved

The administration of a general anesthetic is always attended by some element of risk. Its use should be determined by the nature of the case, as well as by the needs of the patient. There should be little need to use general anesthesia routinely for such operations as cavity preparation, prophylaxis or (as reported) for the placement of "x-ray" film in the molar areas. "The bringing of a human being to that state in which life in so many ways resembles death is at no time a fool's occupation." This is still sound doctrine. I understand it to mean that general anesthesia is not the treatment of choice for operations, which may be successfully managed by using local anesthesia or other methods.

I do not believe in a brusque or ruthless method of dental practice for children or adults. I do believe in the use of anesthesia in dentistry as a desirable aid in complete treatment. A correct individual approach, the use of topical anesthetics, and proper instruments, will assist in the successful management of most dental operations under local anesthesia. The patient will benefit from the unhurried attention of his dentist, and should react favorably to the best methods of modern practice. The use of a local anesthetic is occasionally contraindicated, but these instances are relatively rare.

The use of local anesthesia requires skill, patience, and devotion to detail. It presupposes a practice where patients are treated as individuals, rather than as unconscious numbers recited from a dental chart. There is considerable satisfaction when an alert youngster, or even an adult, has been treated successfully while fully conscious of the nature and extent of the operation. This practice is good for the dentist. As for the patient, I believe it is not only good for his teeth—it is good for his soul.

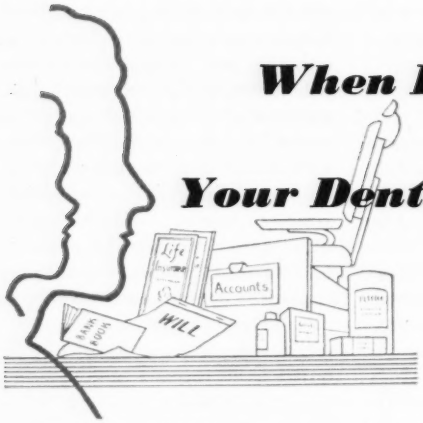
516 *Locust Street*
McKeesport, Pennsylvania

TALK, TACT, AND TREATMENT

THE TRUTH about "doctor-patient" relationships is, I believe, almost impossible to ascertain. We physicians rarely know what our patients think of us and rarely learn what effect our talk, tact, and treatment have had. "He was so enthusiastic I didn't like to offend him" is commonly the attitude of the patient.

Occasionally we get glimpses of the truth when we overhear a conversation on top of a bus or when patients' remarks are relayed to us by a friend (or more likely an enemy); but in the main we remain ignorant, and perhaps it is happier that we do so. —RICHARD ASHER, M.D., *The Lancet*, London.

When Death Ends Your Dental Practice



BY LEO B. DILLON, D.D.S.

IN RECENT years the practice of a number of my professional friends has been brought to an abrupt close by disability or death. The year 1955 will terminate the practice of a number of us. Suppose death strikes you or me without warning. What then! Worse, suppose sudden illness or accident strikes at a time when we have some message or detail that we want attended to, and being unable to convey it to our family, we must die with our wishes unfulfilled. To avoid this, consult those who are informed and interested in you, your estate, and your heirs, for information relative to this important matter. Here are some suggestions:

Step 1—Bank Accounts

All bank accounts and safety deposit boxes for you and your wife should be joint accounts and with rights of survivorship. Otherwise, your wife cannot withdraw any money until after the estate is settled. Contracts for this form of banking can be obtained at your bank.

Step 2—Your Will

Conditions change, such as children being born, attaining college age, or reaching adulthood. All are factors that may mean changes you want to make in your will. The acquisition of sons-in-law or daughters-in-law, the birth of grandchildren, and the death of spouse or children—all make conditions requiring changes in your will. Bring your will up to date. Estate planning is much more comprehensive than making a will. It involves the arrangement of one's estate while he is still living, so that when he dies a minimum amount of money will be lost to

You will be able to practice dentistry better and your wife and heirs will be spared unnecessary hardships, if you take certain steps now in preparation for the eventuality of a sudden death.

his heirs through estate taxes and administrative costs. Be sure that your will provides adequate protection to your estate. Consultation with both your banker and your lawyer can help you attain these ends.

Step 3—Insurance

As time passes and the need of having insurance for protection increases or decreases, you might want to increase your insurance, or direct present insurance benefits into other channels of investment. Let us bring our insurance program up to date by calling our insurance advisor and talking over our problems *now*. Also, it is well to consult the trust officer of your bank to be sure that your insurance does what you wish it to do.

Step 4—Taxes

Taxes are a painful problem for the living, so we should have our taxes in a correct and understandable form for our heirs to view. Income tax should be carefully estimated and changed as business changes. The tax program should be kept in a written memorandum file—not only your income tax, but all other taxes, with your city, state, and county tax, and licenses too.

Consider the Federal estate tax as well as your State estate tax to see if your accounts as valued by a tax appraiser are of sufficient size, so that this tax could be collected from your estate. It is necessary for you to be careful and have in your ledger, from which your statements are prepared, only accounts that the statements are made to cover. All other accounts that you carry, such as accounts for relatives, clergymen, or patients who really should be classified as charity (whom you charge, but never send a bill), and ancient accounts—all these accounts should not be put with those for which statements are rendered and payment expected. The total accounts carried in the ledger are classified in accordance with government rules as to the percentage of them considered good. This figure is added to the other assets of your estate. For example, supposing you carried $20,000 worth of accounts in your ledger. Say that you know definitely, if you were here to collect them, that only $15,000 of these accounts are current and collectible (and much less would be collected if you were deceased); yet your books show $20,000; your accounts would be quoted as $20,000 and not $15,000.

Step 5—Disposition of Your Dental Effects

If you have any sentiment attached to any of your office effects and these feelings would cause you to want to dispose of them personally, then include them

in your will; otherwise, your wishes should be made known either by written or spoken instructions to some responsible party. If your equipment and instruments are old, or some are old and some new, perhaps you would want an institution to have them, as they would have little monetary value for your heirs. Dental supply dealers can offer little money for this old equipment. An advertisement in a dental periodical could bring this equipment to the attention of a recent dental graduate employed at a salary, who not being able to afford new equipment, could buy this old equipment for a little more than the supply house would offer, recondition it, and then start a practice.

Confusion and doubt, arguments, and delays, will be prevented if these little details are made known to someone.

Step 6—Disposition of Your Office

If you own your office building, then your will should state its disposition. If your office is rented from an agent, your estate is subject to the provisions stated in the lease as to the disposition to be made of the office at your death. In the building where I am located, the lease terminates at my death. However, the agents have been considerate in letting heirs retain the office space a reasonable length of time, to dispose of equipment and make arrangements to collect or dispose of accounts, which is about sixty days. However, if no one is demanding the space, I think the heirs could keep it as long as they pay the rent. If someone wanted to buy the good-will or the practice, equipment, and the lease of the deceased dentist, I believe the estate could make a deal through legal channels satisfactory to the building agents, purchasers, and the estate. These problems could be cared for more according to our wishes if we informed ourselves, while we are in good health, as to our heirs' rights and privileges at our death. We should read our leases carefully, and have our attorneys read them, to obtain the information we want.

Step 7—Disposition of Unused Supplies, Amalgam, and Gold Scrap

Marketable dental supplies that are unopened can be returned to the dental supply house for full credit. Old supplies unopened are valueless. Make an annual inventory and turn back what you have ceased to use now while it still has a marketable value. For example, amalgam scrap is not of great value. Some men save it from year to year and sell it and give the proceeds to the Relief Fund of the American Dental Association. Maybe you would like to give one last contribution to this Relief Fund. So in your instructions, designate that your amalgam scrap (and also include your gold scrap) is to be sold, and the proceeds donated to the American Dental Association Relief Fund. Do not let too much scrap accumulate.

Step 8—Your Accounts

If the bank is designated as an

executor of your estate along with your wife, the bills can be collected with a minimum amount of loss. You cannot expect your wife to attend to these things promptly at such a time. When the bank is not designated as an executor of your estate, it is well to make other arrangements.

When some of my confreres die, it seems a few of their patients suddenly develop imaginary relationships that are most fantastic. These patients report concessions that have been granted them (unknown to office help and heirs) by these confreres, which we think they never would have made. In the warped minds of some persons, when the dentist died to whom they owed a just debt, that automatically cancelled the debt! The answer to some of these hatched-up problems for the heirs who have not dealt with situations of this sort before may be, "Well, if you say Doctor said this, we will go along with you." A better answer would be, "Did Doctor say these things in front of either his secretary or his assistant? If not, I am afraid the account will have to stand as is."

To avoid disputes between heirs and former patients, the following letter could be sent soon after death of the dentist to all patients who owe money to the dentist:

Dear Mr. Smith:

I extend my sincere thanks for the confidence that you placed in Doctor Doe during his lifetime. It is my wish to cooperate with you in every possible way to settle your indebtedness to Doctor Doe's estate. This office will remain open ————days, during which time you will be able to call and make your wishes known to either myself or Doctor Doe's secretary. All accounts for which payment has not been arranged satisfactorily previous to Doctor Doe's death, are now due and immediate settlement preferred. It would be much more satisfactory to have the settlement of this account made direct with me. I cannot hold this office indefinitely, and since I need a centralized office where payments can be conveniently made by Doctor Doe's patients, it is strictly a business necessity that I turn these accounts over to ———— Agency after ———— days. This is, of course, no reflection on your credit reputation, but a matter over which I have no control. Since I wish to spare you the embarrassment of a personal call by their collector at your place of business or employment, won't you please cooperate and let me hear from you prior to the ———— date when this office will be turned over to the rental agents?

Sincerely yours,

The wife, or other heir, can consider the fact that money paid to a bank or collection agency will be far less than she would lose trying to collect the accounts herself, and she would avoid all the headaches involved in this hazardous business.

These banks and collection agencies know all answers to the debtors' excuses, delays, and complaints—and the time saved in settling the estate is an important item. Then, too, after the heirs give up the dentist's office, some place will have to be designated where the accounts are to be paid.

Conclusions

Dentistry as a profession is exacting, tedious, and concentrative. Therefore, the mind as well as the physique must be in condition for the performance of the best service. It has been described thus, "Dentistry is the perfection of minute details." Therefore, these details add to the comfort and morale of the dentist in and out of his office. So, in your plans for the future, do something that will go a long way toward making you feel contented and happy, practicing with a feeling of pride and a sense of satisfaction, so that if a calamity or sudden cessation of your life or faculties occurs, that which you plan for your heirs and loved ones will be carried out exactly as you desire it.

916 *Woodward Building*
Birmingham, Alabama

PHYSICIAN URGES BLUE SHIELD FOR DENTISTS

DOCTOR Morris Brand, medical director for the Sidney Hillman Health Center in New York, urges the dental profession to take the initiative in prepayment plans for dental care as the medical profession did in establishing Blue Shield.

Doctor Brand bases his call for action on studies which show that in 1953 the average family spent about $178 for health, including $75 for physicians' fees and $33 for dental care.

But in the same year, he reports, the statistics show that 50 per cent of all hospital charges were paid by insurance programs, 38 per cent of surgical expenses were paid by insurance, 13 per cent of physicians' fees were covered by such prepayment, but that only 3 per cent of dental expenses were covered by prepayment plans.—*Pittsburgh Post-Gazette.*

HOW TO LIVE LONGER

IT WILL be difficult to persuade the more successful exponents of our way of life that the best thing they can do to live longer is to lower their standard of living.—*Ernest H. Klepetar, The Spectator, Philadelphia.*

What I Learned from Wilbur

BY ROBERT P. STICKLEY, D.D.S.*

It is difficult to explain what I put up with in Wilbur. This time, however, he has gone too far. I came home from the office the other night and Mary had creamed sweetbreads for dinner. It is my favorite dish, and I have learned that when she has sweetbreads, she is up to something.

Well, this was it. She and Jane, Wilbur's wife, are good friends. It seems that Jane uses a household budget system, which, no doubt, is one of Wilbur's ideas. Anyway, Jane had completely sold Mary on the idea.

You men know how women are. If you give your wife $50, or $10, the answer is the same. You do not get any money back. To give her a weekly sum to handle all the household bills is suicidal. However, Mary argues that marriage is not just an excursion into the realm of romance. It has definite economic implications. The man has, in reality, taken on a business partner and, she says, it is always advisable to treat a partner in a business-like manner.

She cited that good husband-and-wife financial arrangements can vary. The wife can ask her husband for money as the need arises— this is often embarrassing and humiliating. She can have charge accounts at the stores, which calls for an explanation after the money is spent and can lead to much misunderstanding and unhappiness. Or husband and wife can have a joint bank account, in which case neither party knows exactly where they stand, and a spending race develops to satisfy the needs and desires of each.

The dignified, sensible way, Mary said, was for the wife to be on a weekly or monthly budget. Of course, provided she can present a budget which looks practical and

*This is the fourth of a series of eight informal discussions of various aspects of practice management between two practitioners with divergent ideas on practice building and security.—The Editor.

workable. Sometimes this can be worked out better by both of them. At this point, I told Mary that if she insisted on having a budget I would be glad to work out one for her. She stated that she had drawn her budget already and did not need my help. By this time I had eaten so many sweetbreads I did not have the energy to resist her. While I am sure Wilbur is behind the whole scheme, I decided to give her a few weeks to try it, knowing she soon would be running back to me with her accounts utterly confused.

These are the items in Mary's budget. She admits there are many things to be improved in it. However, she says it has worked well for Jane.

1. Groceries
2. Personal Cash
3. Personal Clothes
4. Cleaning Woman
5. Laundry
6. Drugs
7. Yard Man
8. Utilities
9. Telephone
10. Dairy
11. Children's Clothes
12. Children's Allowances
13. Gifts and Flowers
14. Bank Service Charge
15. Christmas Savings
16. Special Funds
17. Emergency Fund
18. Extras

As you can see, some of these items are paid monthly, but Mary has figured what each amounts to in a year and divided it by fifty-two. This figure she sets up in a weekly budget.

Item 13, Gifts and Flowers, is a sum set up to take care of flowers for the sick, birthday gifts, and so forth. It is, of course, an approximate figure, but it helps to have a fund set up for possible use.

Item 17, Emergency Fund, is a small bonus fund to take care of deficits in other budget items.

Item 18, Extras, is really not a part of the budget. It is to take care of extra items, which arise unexpectedly. Usually these expendi-

	Groceries	Personal Cash	Personal Clothes	Other Items
Weekly Amount	**$25**	**$5**	**$10**	
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

tures are discussed and agreed upon before the money is spent.

In the accompanying illustration a small section of Mary's budget is shown.

The amount available per item for the next week is put at the head of each column as a guide. Money spent each day is set up in the item column and the day column. The columns are added at the end of the week and checked against the budget allowance for each item. The total expenditure for the week is then checked against the total budget allowance for the balance.

Each week, Mary presents the budget to me, and I usually put up an argument. Mary then resigns her position and just hands me the budget. I take one look at it and hand it back to her with a check. Looking over Mary's budget the first time, I told her that since I was not on a salary and my collections were not as good the last weeks in the month as they were in the first weeks, I was not sure I could meet her budget promptly each week. She replied that she understood this situation, but would present her statement each week so that I would have an account of what she was due and could arrange to pay her allowance as soon as possible. She stated that by knowing what she could expect, she was able to arrange any necessary charge accounts in such a manner as she could reasonably expect to pay them.

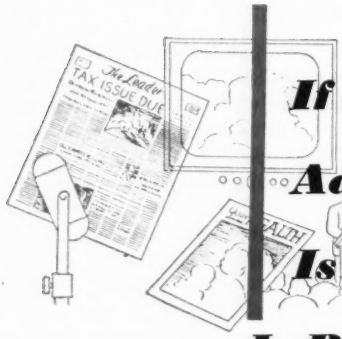
I would not let my wife know it, for women are so likely to get out of hand, but this budget allowance is not as bothersome as you might expect. And too, it relieves me of unexpected demands. I do not have to worry about any bills in connection with my home. All I have to do is pay Mary's allowance, and from there on it is her responsibility.

Somehow a change has come over Mary. She has perked up until she is almost "biggety." It is remarkable what a woman can do when she has complete responsibility for money. It is an incentive for her to develop an economy of getting dollar value for every dollar spent. We eat better, dress better, and argue less. Frankly, it is amazing to me how in the few years we have been married, she has absorbed so much sound business judgment from me.

100 *Quinlan Street*
Lynchburg, Virginia

THE COVER

FISHERMAN'S Wharf, pictured on this month's cover, shows small ships anchored at the dock in San Francisco, after a day's haul. Restaurants located nearby serve tempting fish entrees, one of the many attractions for members attending the ninety-sixth annual meeting of the American Dental Association to be held in San Francisco from October 17 to 20. Applications for hotel reservations should be sent promptly to the ADA Housing Bureau, 61 Grove Street, San Francisco 2, California.



If Dental Advertising Is Wrong. Is Publicity Right?

BY M. A. PATRICK

IT IS perfectly proper for a dentist's wife to purchase and profit through the use of an energy-saving home appliance she has been urged to accept through a commercial-type promotion effort. But the prospective patients of this woman's husband must learn of the physical, mental, and financial advantages of professional dental services, only by chance through some inefficient roundabout way.

Even though dentistry is well organized in holding to such beliefs, there still is something wrong with a system that permits fully 80,000,000 Americans to disintegrate into dental cripples because enlightenment has been purposely withheld from them.

This is especially true, considering that the profession itself is not averse to enjoying the advantages of word-of-mouth advertising in developing appointment schedules. A patient tells friends of "his dentist"; they in turn mention the professional man's name to others, and the resulting chain reaction multiplies the number of the dentist's patients. A single suggestion may lead eventually to the addition of fifty or more names to a dentist's list. There is nothing basically wrong with a development of this kind, although it is comparable to the word-of-mouth advertising that follows the introduction of a product or commercial service to a person who is eager to share the pleasure of his discovery with others.

In addition to its operation in private practice, this pyramiding process is found also in many professional referrals. A general practitioner who sends a patient to another man is not motivated by the pleasant sound of the specialist's name; neither is he always personally acquainted with the specialist's operating proficiency. More likely the "grape vine" has

Housing Bureau, 61 Grove Street, San Francisco 2, California.

It is the company they keep that makes some words acceptable in some places and taboo in others.

brought him favorable reports, or fellow practitioners have praised the skill of the specialist. Disseminating information in this manner is perfectly proper and usually benefits all concerned, but it is on a plane with forces that aid many consumer items to reach widespread public acceptance.

The error in this condition lies in limiting the potentials of dental education. The 80,000,000 American men, women, and children mentioned previously, are not regular visitors to dental offices because they have not been subjected to intelligently planned dental promotion, and they are probably outside the "reaching" possibilities of word-of-mouth advertising. Because they do not visit dental offices, practitioners have no opportunity to explain personally the profession's potentials; since their associates probably are not dental patients, they also miss this second possibility of being won over.

Create Desire for Dentistry

So long as these conditions exist, there will be no justification in dentists wondering why some people avoid dental care, yet spend generous sums of money for late model cars and large screen television sets. The fact is that these men and women exchange dollars for riding luxury and electronic entertainment because they have been educated to the point of desire. The beauties of the open road, the thrill of having star performers in their living rooms, and the pride of possession, have been paraded before them invitingly again and again. While these claims for the consumer dollar are being made, dentistry remains silent as to how it improves physical well-being, steps up social acceptability, and provides increased opportunities in trades and business. Knowledge of these advantages is left to chance, and chance lets dentistry fall into the "also ran" class in the competition for public attention.

Some dentists believe a reluctance to accept and use any force that borders on planned publicity puts them closer to the practices followed by medical practitioners —they have failed to study printed and broadcast material being fed to the public in recent years. Actually, a new type of craftsman has come into being of late. He is the writer who prepares newspaper, magazine, and television scripts when a new drug shows promise, a type of surgery offers hope to certain sufferers, or an unusual mechanical appliance is developed to assist in the medical field. Neither do these men work independently. Frequently they are given the interested help of professional authorities, or they even serve as "ghost writers" when the skill of the medical or surgical

specialist does not extend to a news-like presentation of the subject being discussed.

This type of promotion or publicity has increased the number of men and women who are aware of the need for periodic examinations and prompt treatment for a variety of physical and mental disorders. It is designed to lift the level of public health, and the increase in life expectancy indicates that it is accomplishing its objective. But what about dentistry?

There is a job to be done. Its accomplishment will be hurried if it is made a collective effort, carefully planned, professionally executed, and continued month after month, year after year.

First of all, there is the need to explain that the dentist is a specialist who, like the pediatrist, neurologist, psychiatrist, and others, is specially trained in the treatment and correction of specific human ailments. With this established, the story of other phases of dentistry to be offered an interested public may branch out to cover a variety of dental subjects, with each one titled and phrased to encourage the reader or viewer to think he is being addressed personally.

Promotion Through Writing

Acceptable article material may be built around experiences in private practice, out of clinics where there is access to statistics that give a broad picture, or dentists serving in public health departments of municipalities may explain how certain techniques and treatments are registering improvements in dental health. Even when these men feel unable to express themselves on paper, they still can call upon qualified writers who, after being given all the pertinent details, will carry on from there, and may be willing even to "ghost" the finished piece so that it will appear over the professional man's name.

The market for material of this type is ready and waiting to be approached. Many leading national publications have on their staffs editors who specialize in health-type articles. Program managers of television and radio broadcasting stations also are interested in considering material that simply states facts, or dramatizes the methods professional men use in fighting a health-harming problem.

For years dentistry has shied away from the use of any program that has a tinge of the commercial in it, because of a fear of misrepresentation and individual promotion. But supervised education of the public, such as described here, would cause the efforts of the unscrupulous practitioner to fall on deaf ears. A prospective patient, who has been properly informed, will know the folly of accepting borderline dentistry—the need for constant policing will be less essential. Dentistry has qualifications in which the presently uninformed

half of American citizens can be made interested. It also has limitations, and all America should be told of them. Together these facts offer story potentials that are tremendous, but only dentistry can tell its own story authoritatively. This it must do—and promptly, too.

1007 *North Sixty-Fourth Street*
Overbrook, Philadelphia 31

ANXIETY

ANXIETY IN regard to personal health is almost universally recognized as a characteristic of the human species. It is readily apparent to all that poor health may prevent a person from engaging in many forms of physical, mental and social activity. Therefore, when any individual in the natural process of working out life's difficulties does not find a simple or expedient solution to his problems, it is both convenient and natural for him to employ a health handicap as a subconscious excuse—*The Psychiatric Bulletin.*

PSYCHONEUROTIC PROBLEMS OF THE DENTIST

MOST IMPORTANT of the neurotic problems of the dentist as related to the special features characteristic of his service, is that he operates in a small, cramped, restricted area. This requires a strict limitation of his own motor activity and a constant preoccupation with the problem of pain and the individual patient's response to pain. Second, and of utmost importance, is that the dentist treats the mouth, an area of acute psychologic significance both to him and to his patient.

In the accomplishment of the average daily tasks in life, all of us use motor activity in all its protean forms as a means of discharging normal amounts of aggressive impulses and drives. Because of the peculiarities inherent in his professional service, and also because of his personality type, the dentist is excessively limited in such motor discharge of aggressive impulses. Because the patient anticipates pain, and since all people resent the inducer of pain, the dentist is even more constrained and inhibited from the generation and discharge of even relatively normal quantities of aggression. As a result of this special situational stress, the dentist has an increased struggle with his own already excessively inhibited aggressive drives. The resultant neurotic derivatives and conflicts that the dentist is prone to, therefore, will tend to some considerable extent to have their unconscious roots in the inhibition of normal discharge of aggression.—STEVEN HAMMERMAN, M.D., *Pennsylvania Dental Journal.*

Improving Speech — Dentistry's Opportunity

BY HOWARD E. KESSLER, D.D.S.*

THE MOUTH is the instrument for speech. The dentist is the specialist of the mouth. Some dentists do not realize fully that their specialized knowledge of the human body can be used to correct defective speech, and to maintain the normal speaking ability of their patients.

Knowledge and study of speech production is a relatively new field. This is difficult to understand when one realizes that speech is now and always has been the most important medium for the communication of ideas.

The American Speech and Hearing Association has done a highly successful job of setting high standards for speech therapy. However, among the 3,161 members of the Association, there are but four dentists. Since our part in the speech field depends usually upon our cooperation with the speech therapist, it would seem that more dentists should belong to the American Speech and Hearing Association as associate members. In a study that is so relatively young, the frontiers are not yet rigidly established, and it would seem to behoove dentists to occupy their rightful place in this field.

When we ask again why emphasis on this study has been so recent, we must consider the fact that perhaps the study of our "speech organs" was confined to viewing them in the light of their true origin. We have nothing in our bodies which can be classified as a speech organ. The muscles which form the air power of the voice are muscles which are primarily for sustaining life in breathing. (In the case of an emergency, speech immediately surrenders these areas to their primary function. While in the middle of speak-

*Doctor Kessler is a dentofacial speech consultant for the Cleveland Public School System, and a trustee for the Cleveland Hearing and Speech Center of Western Reserve University.

You are in a unique position to aid the speech therapist, physician, and orthodontist to improve defective speech.

ing, no matter how important the subject may be, if an emergency in breathing occurs, speaking abruptly stops and breathing takes over in its primary and dominant role. This is exemplified in a needed breath or cough.) The articulatory muscles are the muscles of mastication. (The hieroglyphic script of the ancient Egyptians showed the identical picture-sign for eating as they did for speaking. This was a kneeling man pointing to his mouth with his finger.) Even the vocal cords are primarily for the protection of the trachea.

Speech defects can be caused by any of the following factors:

1. malocclusion
2. prognathism
3. loss of teeth
4. tongue
5. cleft palate
6. shortness of soft palate
7. dentures or bridges planned without regard for phonetic consequences
8. fear of showing unsightly dentition.[1]

To this list we have found it necessary to add a 9th factor, namely, ankylosis of the temporomandibular articulation. Persons with this condition must speak through securely clenched teeth.

The first view of the human vocal cords in action, according to Sterling MacKinley,[2] was not recorded until 1854 when, in France, Manuel Garcia used a dental mirror to view his own larynx in the reflected sunlight.

Speech is voice modified and controlled by articulation. Voice alone constitutes the quality, intensity, and pitch level of the sound. As dentists, we are concerned primarily with the speech rather than the voices of our patients.

Voice specialists and lovers of the vocal arts have complained that our generation has become a vocal slave to the microphone. Radio, television, and movie actors and actresses, are becoming so dependent upon the mechanical help of the microphone that many of them are afraid to appear in plays where they must of necessity use their naked voices. The voice carried through a microphone is not the true quality of the individual voice, but a filtrate controlled by the sound engineer. This mechanization can make a strong, well-projected voice out of a weak one.

On the other hand, while the microphone distorts the quality of the voice and makes it easier for poor, weak voices to "get by," it also intensifies speech defects, such as lisping, and calls attention to them. Thus, the present-day use of the microphone makes the role of the dentist even more important.

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[1]Kessler, H. E.: The Relationship of Dentistry to Speech, JADA **48**:44-49 (January) 1954.

[2]MacKinley, Sterling: The Genius of Manuel Garcia, Musical Opinion, London (September) 1948.

The need for speech research on the dental level is great. We still do not have the final answer as to just exactly what part malocclusion plays in causing speech defects. Some of the research results have been conflicting. We are still looking for exact answers to the following questions: Why do some individuals with severe malocclusion have perfect speech? Do these people compensate for their malocclusion by compensatory lip and tongue placements because of a high Intelligence Quotient? Do children compensate because they are surrounded by parents and friends who have good speech and whom they imitate? Does the exact amount of overjet of the arches decide whether or not this individual will have difficulty with his or her sibilant sounds? Has the width of the upper arch anything to do with it? Does the height of the palate vault have any influence? Is the width of the palate significant? How does one account for the children and adults who have perfect occlusion and yet lisp? What about the belief that some malocclusion can be caused by a speech defect, such as the pressure of the tongue during faulty speech, tending to push the upper anterior teeth into protrusion? Is there a connection between "tongue thrusting" and speech defects? What about faulty swallowing habits?

The dentist who is a student of speech has a great advantage in this day of television, radio, words, and more words; that is, he seldom gets bored hearing others. Instead of listening to the "what" in an unending stream of words, which are poured upon us from every direction and through many mediums, he can concentrate on the "how" and the "why." In analyzing speech in this way, he is turning what can be one of the most boresome modern situations into an interesting and valuable practice.

We all analyze the voices around us unconsciously. Some voices please us because they are sincere, pleasant, and sexually normal. A man's voice which is high, thin, and without masculinity, sometimes revolts us almost as much as the affected female voice.

However, if the dentist deliberately analyzes the speech around him, often it will tell him much of the background, general health, and condition of the mouth of the speaker. Television is a boon for the dentist in this regard. Here he actually can see clearly the speaker with the severe Class 2 bite attempting to compensate with his tongue, while producing the sibilant sounds. While listening to the radio, the dentist can concentrate and envision the articulatory processes going on.

In general, most cases of defective speech are handled best by full cooperation between the speech therapist, dentist, physician and orthodontist.

When the dentist realizes that

down through the centuries the spoken word has been one of the chief forces behind all human progress, he should be proud of the role he plays in maintaining the normal speech of his patients and in helping to correct defective speech.

The Park Building
Cleveland, Ohio.

PEPPERMINT AND CARIES

A CASE of widespread and rapid destruction of a man's teeth by caries attributed to the abuse of peppermint lozenges was published in *Deutsche Monatsschrift fur Zahnkeilkunde* by Scharnweber about 1912. The author saw the cause of it not in the peppermint, but in the sugar content of the lozenges. He came to this conclusion because the condition of the teeth (caries beginning as cervical caries, spreading over the buccal surfaces) was similar to the caries formerly seen so often in the mouths of people employed in the manufacture of cakes and confectionery.—P. ROSTEN, *British Dental Journal.*

WE WILL ALWAYS NEED THE DENTAL ENGINE

WE DO not think the Cavitron is ready to replace the dental engine. There is no question but that the Cavitron is most promising, but dentistry has conducted too many post-mortem examinations on previous disappointments, and it is time we should be cautious before releasing publicity regarding scientific advancement beyond the satisfaction of research and clinical experimentation.

It is necessary to exercise caution pertaining to ultrasonics, space ships, and induction of anesthesia by electricity. A professor from Tokyo Medical and Dental University, who was in the United States, met with a degree of success in demonstrations of his machine and technique for effecting anesthesia through the use of electricity. Here again, we believe time and further research to be an essential before placing the matter before the general public.

It is to the credit of several dental manufacturers that they are aware of the necessary research yet required before the green light is given to the indiscriminate production of the Cavitron.—From an editorial, *The Texas Dental Journal.*

How Does Stress Tend to Produce Illness?*

THE EXTENT to which exposure to life stress contributes to illness has long been a matter of conjecture. In an effort to clarify this relationship, an epidemiologic survey was undertaken by Doctor Lawrence E. Hinkle, Jr., of Cornell University, among a fairly homogeneous segment of the general population. The results should interest any physician who thinks of his patient as something more than just an aggregate of body systems.

In planning the survey, it was first determined that certain conditions would have to be fulfilled in order to assure meaningful statistics. First, the group would have to be drawn from an essentially well population; thus, hospital patients were automatically excluded. Second, it would have to be a group in which prolonged observation was possible and medical records were available. Third, living conditions would have to be fairly equitable among the members of the group, leaving as the major large variable the degree of stress encountered by the different persons. It was felt that these requirements would be best answered by selecting employees who all held the same type of position in the same location. A group which apparently met these specifications was found within the telephone company of a large metropolis, where records on over 1300 women telephone operators were available for study.

Preliminary examination of attendance records soon revealed that sickness disability was not distributed evenly throughout the group. Neither was it a random factor. Instead, it fell into a repetitive pattern. Within the span of one year, roughly three-quarters

*Reprinted from the article Illness as a Reaction to Stress, *The Psychiatric Bulletin*, University of Texas, Houston, Spring, 1954.

Survey of* 1300 *women telephone operators yields some interesting answers.

of the absences were attributable to but one-quarter of the women. Since the record for one year could not be considered a decisive sampling, 20 women from the highest absence group and 20 from the lowest were selected for intensive examination. Medical records on all these women extended back for 20 years. Analysis of the records uncovered facts, which had not been anticipated by the employing organization.

The analysis showed:

1. Year after year, certain persons became ill more frequently than others.

2. These same individuals suffered more varieties of illness than did the others.

3. The same group had more disabling accidents than the other employees.

Interviews were then conducted in an effort to determine what life stresses might be rampant in this group, and to compare this with the conditions found in other groups.

No appreciable difference was found in the heredity or family histories of the two categories of women. Economic background was fairly constant throughout both groups. Opportunities for exposure to infection were not noticeably higher in the "ill group." The only factor in which a conspicuous difference appeared was the prevalence of emotional stress. The group of well women all expressed themselves as being generally satisfied with their lives as they found them. The ill women, on the other hand, remained in a state of chronic emotional tension as a result of discontentment with their respective life situations. Referring to women in the "ill group," investigator Hinkle said, "they had spent their adult lives in situations of insecurity and frustration, working at a job which they disliked, having little recreation, little security, little satisfaction in life." The well women, however, had no unwanted family responsibilities, and spent their lives contentedly in an occupation of their own choosing. The woman's individual needs, as determined by her early conditioning, and the way in which these needs were answered, appeared to be the most important factor in determining a chronically stressful situation.

Diagnosis of Stress Disorders

In dealing with stress disorders, diagnosis of the patient's condition embraces both physical and psychologic manifestations, although both components are part of the total reaction. The search for organic damage proceeds through usual diagnostic measures. Most likely, the patient will show a combination of physical and psychiatric symptoms which, taken togeth-

er, add up to a multiple diagnosis. Usually, the more pressing physical disturbances will receive first consideration, since they are ordinarily cited as the presenting complaint.

It is more difficult for the general physician to evaluate psychologic maladjustment, because the symptoms are often nebulous and transitory. The patients themselves may not be helpful immediately in uncovering sources of stress. Usually, they are unaccustomed to having to correlate the appearance of symptoms with events in their daily lives. In many cases, they may not recall any stressful event, or they may have even repressed the knowledge that stress existed. Indeed, the distinguishing characteristic of neurotic reactions is that the anxiety underlying the formation of symptoms is largely unconscious.

Psychiatric diagnoses, of course, are made by examining the patient and studying his history. While assembling the history the physician gets his first indication of possible sources of stress. For the manner in which the patient expresses himself and the points at which he displays emotion convey important information to the alert observer. When the voice falters, eyes fill with tears, hands become fidgety, or the chain of thinking becomes blocked, the physician will recognize that a touchy subject is being approached. As Doctor Hinkle observes, "One quickly learns to recognize and evaluate sensitive topics by their symptoms and signs, and to investigate them cautiously, with due respect for their tenderness, much as one would palpate a furuncle."

Often the physician can help the patient discover the source of his stress. The physician may inquire, for instance, "During previous sieges of illness, were there any disturbing factors present in your home life, or in your work?" Sometimes such an inquiry will lead to the patient's first realization of the nature of a basically stressful condition in his life.

In recording the diagnosis, it is helpful to indicate what is producing stress upon the patient, as well as an estimation of his capacities for resisting it. This may prove useful in establishing a prognosis and determining the patient's possible susceptibility to further illness.

Therapy in Stress Disorders

Therapeutic measures of several types may be required for patients with stress disorders. After appropriate medical and surgical therapies are applied, there may be some residual psychologic disturbances. If this is not recognized and alleviated, new psychophysiologic symptoms may appear at any point in the body. Therefore, it is important to deal with the emotional factors.

Some physicians believe that the more closely an episode of illness

is related to a situation of stress, the closer the trouble is to the surface and the easier it is to rout. Severe psychologic disturbances are harder to connect with stressful stimuli than are the minimal, transient ones. In a patient with a previously well-integrated personality; that is, one whose life adjustment has been generally satisfactory, psychotherapy of a superficial type should be adequate. This consists of such measures as emotional catharsis, or letting the patient "talk it out," explanation and reassurance, and manipulation of the environment. Although this is termed "superficial psychotherapy," it is superficial only by contrast to the uncovering of unconscious conflicts which are deeply pathologic.

The physician's general attitude is highly significant in psychotherapy. In order to get a more meaningful history, the physician shows that he is interested in the patient personally, takes time to hear him out, and accepts uncritically whatever he has to say. Often feelings of self-blame are present, and one of the strongest therapeutic factors at work on the patient is his discovery that his physician accepts him without condemnation or surprise. Thus, feelings which have been too painful for the patient to face become mitigated, and are divested of much of their ability to produce psychic pain.

The physician can explain that with the passage of time, individuals develop characteristic patterns of dealing with painful feelings, and these can prove costly by taking a toll on their health. The explanation need not be involved; in fact, the simpler and more casual it is, the more reassurance it carries. Reassurance is furthered by some additional physical tests, although it is wise for the physician to tell the patient that he expects these to be negative. This will preclude a suspicion by the patient that the diagnosis is incomplete. Manipulation of the environment is often possible after the physician points out that if the stressful situation persists, the patient must expect to pay for it in terms of his comfort and possibly his health. When he views the situation from this perspective, the patient may be stimulated to make some changes for which he had not seen the necessity before. The experience of facing and thrashing out a disturbing situation with his physician aids the patient by strengthening his resources for meeting further stress. Accomplishing this may take a little more time, particularly in the initial interviews, but the time required cannot be said to be wasted. The time spent is better invested, since it establishes a worthwhile basis of lasting confidence. For the physician who knows his patients well has a valuable therapeutic tool and a better opportunity than anyone else to make his therapy effective and of continuous value.

Pictured above at the Eugene, Oregon, Dental Clinic are left to right: L. L. Small, Elks Dental Committee; Doctor George B. Hull, President of the Lane County Dental Society; Mrs. J. E. Temple, Dental Assistant; Doctor Madeline Marr, Director of Health Education; B. R. Marlett, Elks' Exalted Ruler; W. A. VanNuys, Elks' Secretary.—Photograph Coburn Film Shop.

Cooperative Dental Care for Indigent Children

BY GLEN L. PURDY, D.M.D.*

HUNDREDS of children in Lane County, Oregon, have received desperately needed dental care the past six years at no cost to them.

Under a plan worked out by the Eugene, Oregon, Elks Lodge Number 357, with full cooperation of the Lane County District Dental Society and school medical personnel, the first small Elks Dental Clinic began operation on an experimental basis during the 1948-49 school year in Eugene, which is a city of about 40,000.

The project was initiated that year with a $1000 donation from the Elks Lodge. School nurses selected 137 pupils in extreme need

*Editor, Lane County District Dental Society.

The Elks Lodge of Eugene, Oregon, and the Lane County District Dental Society have pioneered a dental clinic giving free treatment to needy children.

of dental care. These were examined by 12 members of the Lane County District Dental Society working in pairs in their own offices.

From these dental charts, it was estimated that the cost of correction, using the Oregon State Industrial Accident Commission fee schedule, would have exceeded $8000. Therefore, 36 children were chosen for care of permanent teeth at a cost of $821. The rest of the initial donation was spent for extractions.

The following year the Elks Lodge arranged with the School District for the purchase of a small piece of school-owned property, and the present clinic was built at a cost of about $12,000. Building and real-estate costs were $6,797; equipment, supplies and furniture added $4500.

During the year the clinic was under construction, the Elks Lodge gave an additional $581 for dental care, and the dentists contributed their time.

How has the plan grown?

A few figures show that through continued and increased cooperation on the part of the Elks, the dental society, and school officials, each year more and more children are receiving needed dental care.

The clinic building opened January 15, 1951, and operated until the end of the following May. During this time, 35 dentists gave 83 half days to the care of 111 patients. Estimated care at State Industrial Commission rates was $3500; the cost of maintenance and supplies was $1,317.33.

In 1951-52, 30 dentists gave 120 half days, attended 140 children. Estimated care was $6000, cost of supplies $2000.

The increase continued in 1952-53, with 32 dentists giving 192 half days to care for 176 patients. Estimated care was $7,605, and supplies were $3000.

Last year 126 half days were given by 35 dentists, who cared for 178 patients. Care was estimated at $10,584, and supplies at $5500.

Members of the Lane County District Dental Society contribute their services to this project—one of the few such projects in the Nation.

The rather steep increase noted in the estimated service given, results from the increase of special services, such as complete and partial dentures, and space maintainers. Dentists who do not serve at the clinic often give these special treatments in their own offices.

Some dentists, living in towns near Eugene, give the dental care in their own offices to save travel time for themselves and the children.

As for the Elks Lodge—it has spent nearly $20,000 since it started this dental program. Expenditures include those for construction, equipment, supplies, maintenance, and the salary of a dental nurse at the clinic. The clinic is the major charity program carried on by this Lodge, and the project has been nationally recognized.

According to John T. Foreman and Lyle Small, members of the Elks Dental Clinic Committee, this is the one phase of the Eugene Elks Lodge charity program that has the wholehearted support of all members.

Clinic Committee

The Dental Clinic Committee is composed of these two men, two members of the Lane County District Dental Society, and the school physician of the Eugene Public School District Number 4.

Requests for dental care in Eugene schools are cleared by the school principal and school nurse as to urgency of needed care and financial inability of the family to pay. The cases are then reviewed by the school physician.

All requests for care outside School District Number 4 are made by the county school nurses. These written requests outline the full family situation, including income, size of family, and other pertinent material. These cases are reviewed and passed on by members of the Dental Committee about once a month. Final decision as to acceptance or refusal of referred cases lies solely with the members of this competent dental committee.

When a case is accepted, a note is sent the parents by the school physician. The parents are responsible for transporting the child to and from the clinic. Parents must also sign a statement granting permission for dental care. This is a medical-legal precaution to prevent malpractice suits against the clinic.

When the signed permits are returned to the school physician's office, a dental chart is typed and sent to the clinic. The first appointment for clinic work is made by the school physician's secretary. Subsequent appointments are made by the dental assistant at the clinic.

The clinic opens each year in mid-October, following the annual fall dental inspection in the schools. It is open only on the half days when dental society members are working, is closed during school holidays and vacations, and closes each year the week before Memorial Day.

Clarence Hines, Superintendent of Schools in Eugene, has pointed out that, "The clinic renders an efficient and worthwhile service to the children of Eugene and Lane County. The unusually large number served, the degree of cooperation among the agencies involved, and the great amount of good done the children, have commended the clinic to me as one of the finest cooperative enterprises of which I have known in 30 years of public school work. The Elks Lodge, the Lane County Dental Society, and

school health agencies, deserve great credit for the success of the clinic."

Doctor Harold M. Kramer, President of the Oregon State Dental Association, recently observed that this is the type of program which should be started throughout the United States. He expressed appreciation that as many as 35 members of the Lane County District Dental Society have given their time in a single year to clinic services.

The Lane County District Dental Society is grateful to the Eugene Elks and Doctor Madeline Marr, School Physician and Director of Health Education, for their sincere cooperation in making the project a success.

Eugene, Oregon

FIRST AID

THE PURPOSES of first aid are (1) to save life, (2) to prevent further injury and (3) to preserve resistance and vitality.

The following rules should be observed in case of injury.

1. *Keep* the patient lying down with the head level until his injuries have been determined.

2. *Examine* the patient for hemorrhages, cessation of respiration, and evidence of poisoning. These conditions take precedence in this order over everything else and demand immediate treatment.

3. *Remove* enough clothing to get a clear idea of the extent of the injury. Preferably rip the clothing along the seams, but cut it if necessary. Removing clothing in the usual way may do great harm, especially in fractures. Do not remove too much clothing; exposure to cold may precipitate the conditions of shock.

4. *Do not* get excited. Act quickly but efficiently. Decide as soon as possible what has to be done and which one of the patient's injuries needs attention first.

5. *Keep* the patient comfortable. This can be done while the patient's injuries are being cared for. A blanket over the patient may do him as much good as the dressing one applies to his wounds.

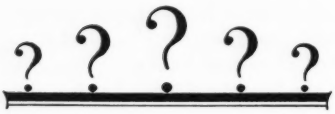
6. *Avoid* allowing the patient to see his injury. Assure him that his injuries are understood and that he will get good care. In some cases a cigarette will make a patient feel better. These little things are important in determining a patient's final outcome and preventing shock.

7. *Do not* touch open wounds or burns with your fingers or other objects. This may cause serious infections and may cost the patient his life.

8. *Do not* try to give an unconscious patient liquids.

9. *Do not move* a patient until the extent of his injuries has been determined.—*Medical Technicians Bulletin.*

So You Know Something About DENTISTRY!



CXXXI

1. True or false? Lower teeth, especially the lower anterior teeth, are as a rule lighter in color than the upper teeth. _____

2. Which of the following habits may cause a malocclusion? (a) thumb sucking, (b) finger sucking, (c) faulty swallowing, (d) tongue thrusting, (e) lip biting, (f) leaning habits. _____

3. When should a silicate-type cement be used to cement a porcelain inlay? _____

4. Rests function to (a) transmit occlusal forces to the teeth, (b) keep clasps and saddles in a predetermined position, (c) prevent food impaction. _____

5. Maxillary cuspid impactions occur (a) as frequently, (b) three times as frequently, (c) ten times as frequently, on the palatal side of the arch as they do on the labial or buccal side.

6. Which of the following medicaments are contraindicated in use with acrylic filling materials? (a) any essential oil, (b) chloroform, (c) phenol, (d) all forms of peroxide. _____

7. Is it possible for acetylsalicylic acid to produce a painful slough or necrosis upon contact with the oral mucosa? _____

8. True or false? The function of a tooth depends on the periodontal structures, not the pulp.

9. Secondary infection of oral cancer tends to occur (a) earlier than, (b) later than, (c) the same as, in cancer elsewhere. _____

10. Do large-grained alloys triturate well? _____

FOR CORRECT ANSWERS SEE PAGE 975

DEAR ORAL HYGIENE

I am for OASI

I am a believer in Old-Age and Survivors Insurance and for that reason I was interested in the articles on this subject in the May issue of ORAL HYGIENE.[1] One article seemed to have summed up fully the point of view that OASI is a poor investment.[2] And the writer of this article does not stand alone, as evidenced by the House of Delegates' continued vote against it. If the argument of this article is not sound, then where is its fallacy? Possibly in dollars and cents, we will not find the answer.

But insurance is not a matter of money alone. We carry heavy insurance against many of the vicissitudes of life, which in dollars and cents will never return the value paid out—premiums paid for malpractice suits, hospitalization, income protection, automobile accidents, fire destruction. But do we term these forms of insurance poor investments? It may be our privilege to be able to practice our profession beyond age 65, and we may be able to provide adequately for our later years during our active years; but if we cannot, possibly due to circumstances beyond our control, or do not do so, what then? This *if* is the same *if* that is the silent partner in all insurance.

OASI is termed by some (not strangers to us) as paternalism, by which is meant, I believe, a state performing certain functions for its people, which they ordinarily perform for themselves. But is this necessarily a bad thing in all instances, and is it in this case? The answer is all about us if we would look, but it is useless to look if we will not see, and some will never see. Before we use the term paternalism too lightly, we should look at ourselves. When a minority opinion stands across the will of the majority, we have a form of paternalism of the worst sort. The history of man proves this. The thought and words of Lincoln are prophetic, to the effect that the majority will more often be right than the one, the few, or the minority. Such is the basic structure on which all democratic institutions are founded.

But regardless of how at the moment our profession may resolve the question of OASI, I believe we may be certain of one thing—in the not too distant future, we will resolve it in the affirmative. We are witnessing a change; we are in a transition period. "I am my brother's keeper" is replacing "Am I my brother's keeper?" barely perceptible though this change may be. OASI is here to stay, for Republicans and Democrats alike; it is a good thing for man individually and collectively; we dentists, too, will shoulder our responsibility for social progress.

Personally, I may or may not have need for OASI; the chances, barring the unforeseen, are about equal either way. But if I did not need it, and knew I would not, (that is, if Mammon had not bested me) I would still be for it for those whom it would help. And it will help those to whom it will be all, those to whom it will be an adjunct to whatever savings they have, and last,

[1]Pollack J. E.: Why I am for OASI, Oral Hygiene **45**:608 (May) 1955; Speak Up on OASI. Dear Oral Hygiene, ORAL HYGIENE **45**:602 (May) 1955.
[2]Kirkland, G. F.: Why I am Against OASI, **45**:604 (May) 1955.

those who do not need it but by participating in it can be partners in the general good.—VIRDEN L. THOMAS, D.D.S. 3310 *West Ramsey Street, Banning, California.*

Instruct Your Delegates

Every state poll taken so far has resulted in a conclusive victory for social security inclusion, which shows clearly that the trend throughout the country is for OASI, but there is one weakness in our dental convention; namely, the nonpledging of delegates.

Dentists desiring OASI should ascertain how their delegates intend to vote at the San Francisco Convention, and if their state is in favor of this inclusion, their delegates must be instructed to vote accordingly. If they refuse, they should be removed.

Dentists throughout the country should also demand that their state take a poll vote on this question. It is evident that only a small segment of American Dental Association delegates are keeping the dental profession from participation in this wonderful old-age pension plan, which cannot be duplicated by any insurance company.

I believe that if all dentists would investigate the benefits of OASI, they would be unanimous in requesting this protection. How long do you think the *labor unions* of this country would allow their members to be excluded from this act?—HOWARD P. HORRIGAN, DMD, 1537 *Main Street, Springfield, Massachusetts.*

Voluntary OASI

Here is a comment on your editorial concerning OASI and the Congress of American Dentists for OASI.[3]

I feel that the editorial power of your publication should be directed toward a *voluntary* inclusion of dentists under the Social Security Act. If the Act is so beneficial, I am sure that *compulsion* of dentists to join will not be necessary. —W. H. GAMBILL, DDS, 6331 *Hollywood Boulevard, Hollywood, California.*

[3]Ryan, E. J.: What Are the Chances for Social Security? Editorial in ORAL HYGIENE **45**:740 (June) 1955.

PATIENT DECIDES TO REPAIR HIS OWN TEETH

IN Mexico City, a patient who grew tired of waiting for his dentist, Doctor Yury Kuttler, apparently decided to treat his own teeth. He walked out with twenty books on dental surgery.

Doctor Kuttler told police the patient asked him for immediate aid. The dentist said he was too busy at the time, and asked the man to wait in the reception room. When Doctor Kuttler went to call the patient later, he had disappeared—along with the books valued at 500 pesos ($400).—*Atlanta Journal.*

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News,* we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be *acknowledged or returned.* When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

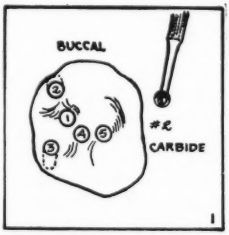
TECHNIQUE of the Month

Originated by W. EARLE CRAIG, D.D.S.

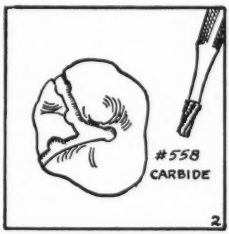
Class II Cavity Preparation

BY ROBERT S. STUART, D.D.S.

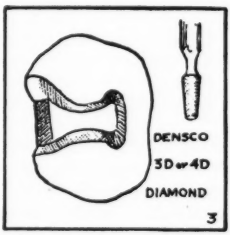
Drawings by Dorothy Sterling



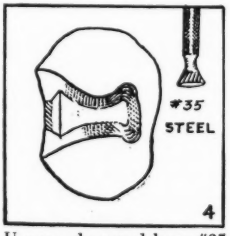
Using a #2 carbide bur, drill 5 (or more) holes through the enamel into the dentine as shown in the drawing. Hole #2 should slant to the lingual, #3 to the buccal, and #1, 4, and 5 should be vertical.



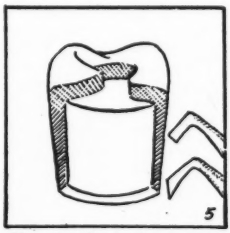
Use a #558 carbide bur to connect the holes and make a Class II outline.



Use cylinder shaped diamond slightly larger than the smaller end of a plugger point (densco 3D or 4D) to enlarge the preparation.



Use regular steel bur, #35 inverted cone, to make undercuts and flatten the floor of the preparation.



Use hand cutting instruments to finish preparation. Smooth buccal and lingual walls of gingival step with enamel hatchets. Use margin trimmers on ragged enamel rods of the gingival floor.

All five steps of preparation should take about five minutes. The #2 carbide bur, air-cooled, cuts very rapidly with little heat and with less vibration than a diamond point. It will not break easily and retains its cutting ability for a long time. On a molar preparation, drill as many holes as possible within the limits of the preparation.

Dentists in the NEWS

Greensboro (North Carolina) Record: For the past year, Mrs. William M. Ditto has headed a statewide dental scrap drive. Under her direction, women throughout the state have invaded their husbands' offices in search of amalgam and other scrap material. The results of this drive netted $1300 for a fund, which has been set up by the North Carolina Dental Society and Auxiliary to assist dentists who are no longer able to practice.

Philadelphia (Pennsylvania) Bulletin: The curiosity and quick wit of a 12-year-old boy saved the life of his dentist, Doctor Nathan M. Nitkin, whose office is at 2701 Tasker Street. Joseph Fisher had a dental appointment for 4 p.m. He arrived a few minutes late, sat down in the reception room, looked at his books a while, and waited to be called, but no call came.

After a while he began to smell gas. Joseph thought it would be a good idea to try to find out where the gas was coming from. So he peeked his head into the office but found no one there. Then he tiptoed back into the rear room where Doctor Nitkin has his laboratory.

There Joseph found the dentist stretched out on the floor, his rubber gloves still on his hands. A Bunsen burner was lit, and the odor of gas was strong. He turned the burner off, then opened a door to a fire escape to clear the air. He called for help, and Joseph Teti dashed up the stairs. Together they carried the unconscious dentist to the street. In a few moments, Rescue Squad 11 arrived and administered oxygen while taking Doctor Nitkin to the Philadelphia General Hospital, where he was revived.

A detective called at the dentist's office to investigate, found the leak had been caused by several holes in the rubber hose, which carried the illuminating gas to the burner. He also attempted to locate the boy who had saved Doctor Nitkin's life. On calling Joseph's home, he found that the boy was out playing ball—mission accomplished!

Brooklyn (New York) News: One of the world's earliest coins, dating back to about 550 B.C. in Greece, was shown in the exhibit of the Brooklyn Coin Club at the Brooklyn Public Library, according to Doctor Lawrence H. Lippman, a dentist of 57 Montague Street, Brooklyn, exhibition chairman. He said that the coin belongs to Cecil H. Ryan, former Brooklyn newspaperman now living in New Jersey. The exhibit included a framed collection of genuine and counterfeit U.S. currency on loan from the Secret Service Division of the Treasury Department.

The Brooklyn Coin Club is a member of the American Numismatic Association.

Chicago (Illinois) Sun-Times: At the eagerly awaited Midwest Premieres of CINERAMA HOLIDAY in Eitel's Palace Theater in Chicago this summer, guests of honor were the stars of the production, Doctor John Marsh, a young dentist of Kansas City, Missouri, and his wife, Betty. Selected by Louis de Rochemont as a "typical" American couple for his second Cinerama production, John and Betty Marsh made their film debut in European sequences,[1] while their counterparts, Fred and Beatrice Troller of Zurich, Switzerland, were photographed enjoying their first visit to the United States.

The opening night in Chicago, featured by giant searchlights, stars of radio and television, bands, and a U.S. Navy Jet Airplane, was for the benefit of the Peacock Camp for Crippled Children of Illinois, and the second night for the International Federation of Catholic Alumnae, Illinois Chapter. All subsequent performances of CINERAMA HOLIDAY will be open to the public on a reserved seat basis, as was THIS IS CINERAMA, the first film ever to be made with a special three-eyed camera for a curved screen. This innovation, which revitalized the whole motion picture industry, broke all box office records in its run of nearly two years at Eitel's Palace Theater, with hundreds being turned away at the last performance. Unlike the first production, which emphasized scenery, CINERAMA HOLIDAY is developed around the adventures of four young people against a varied scenic background.

John and Betty Marsh appeared in person at the New York and Pittsburgh premieres of CINERAMA HOLIDAY earlier this year. The film, which can now be seen at several of the thirteen Cinerama theaters throughout the United States, shows the Marshes enjoying winter sports in the Swiss Alps, attending a High Mass in Notre Dame Cathedral in Paris, visiting the Louvre, at a fashion show produced by a foremost Parisian couturier, the Artists' Ball and other high points of a visit to the French capital.

Johnstown (Pennsylvania) Tribune-Democrat: Honors were accorded by the Johnstown Junior Chamber of Commerce at the annual state convention in Reading, to Doctor Irwin L. Simkins, state vice president, and to Doctor Howard E. Mitchell Junior, whose term expired recently as chapter president. The Eyerman award was given to Doctor Mitchell for the many hours of travel and effort he donated to the interests of the organization. The chapter promotes enlistments in the United States Air Force.

Wichita (Kansas) Beacon: Doctor C. A. Ogg, retired dentist of Douglass, Kansas, has been appointed State Fire Marshal by Governor Fred Hall. Doctor Ogg, a practicing dentist in Douglass for forty years, has been active in political, fraternal, and civic affairs in the Butler County community for many years. He served four terms as mayor of Douglass and retired from dental practice eight years ago.

Atlanta (Georgia) Journal: For the past four years, Marilyn Stone has been the only girl in a class of seventy-four dental students at Emory University Dental school. On graduating this year, Miss Stone said she believed that women are not entering the dental profession in sufficient numbers because there is so little said about their suitability for the profession.

"It is a profession that can be fitted in nicely with having a home and family, because the hours are regular and a woman can have an office in her home."

Buffalo (New York) News: French railroads hope to make their lines safer by using a screw, which a dentist invented to save his patients from losing their dentures. The state-owned enterprise revealed that it has ordered 5,000,000 of the screws to lock the rails more tightly to the wooden ties. Doctor Jean Broggiatti of Biarritz, inventor of the device, died a few months ago.

Des Moines (Iowa) Register: Among the 950 State University of Iowa students who received their degrees, Doctor Jacob Eisenbach, a dentist, has traveled perhaps the most difficult path. Ten years ago, he and his wife-to-be were freed from a five-year ordeal as victims of the Nazis in a camp for Jews in Poland. Doctor Eisenbach received his first degree in

[1]Hurley, Marcella: Kansas City Dentist and Wife Star in CINERAMA HOLIDAY, ORAL HYGIENE **44**:1644 (December) 1954.

dentistry from Von Goethe University in Germany. The Eisenbachs were married in Poland in December 1945.

"It took us some time to get back to good health," Doctor Eisenbach said. "Many prisoners in our camp had died from starvation and disease. We had just enough food to live on." Doctor Eisenbach's brothers, then 12 and 16, his sister, 20, and his father, 49, were killed by the Nazis. Doctor Eisenbach was 16 when the war broke out.

Professor H. Schlossberger, one of Doctor Eisenbach's instructors at Von Goethe University, is a friend of Dean-emeritus Robert E. Buchanon of Iowa State College. This friendship led to the Eisenbachs' move in 1950 to Iowa, where they plan to remain.

"It is ten years now since we were in the concentration camp and we do not think about that much anymore," he said. "We are too busy. But when we do think about it, it becomes fresh in our minds and then we appreciate this country even more."

Philadelphia (Pennsylvania) Daily News: Doctor Malcolm W. Carr of New York City, and Richard M. Marshall, President of Pittsburgh Coke and Chemical Company, have been elected trustees of the University of Pennsylvania. Doctor Carr, a dentist and author, was graduated from the School of Dentistry in 1922. He will serve through April 1958 as a regional alumni trustee.

Portland (Oregon) Oregonian: State Representative F. H. Dammasch, Portland physician and dentist, was recently honored by two groups. He was the guest of honor at the Multnomah Chapter of the Oregon Republican Club in recognition of his services in obtaining legislative authority for the construction of a mental hospital. In the 1933 session of the legislature, Doctor Dammasch introduced the first bill for this mental hospital, which is to be built within twenty miles of Portland. Since the 1933 session, Doctor Dammasch has served five regular and two special sessions, and has been the author of much legislation in behalf of dental and medical education and public health.

At a dinner sponsored by the officers of the Oregon State Dental Association and representatives of the Oregon state and Multnomah county medical societies, an honorary membership in the state dental association was given to Doctor Dammasch.

Baltimore (Maryland) Sun: When Doctor Donald C. Buckley received his doctor of dental surgery degree from the University of Illinois in Chicago, his three children had earned the right to beam with pride and relief. They helped put him through school.

Denise, 7; Donnie, 6; and Michael, 3 —all are professional models whose earnings have helped Buckley pay his expenses. Michael had to secure a social security card at 2½ months to take a job modeling a christening dress.

Syracuse (New York) Post-Standard: The wife of a Syracuse dentist gave birth to triplets—all boys. Doctor and Mrs. John Laura of 435 East Genesee Parkway, became the parents of three boys born six weeks prematurely. The trio, as yet unnamed, weighed separately 4 pounds 1½ ounces, 5 pounds 8 ounces, and 4 pounds 2½ ounces. The couple will be allowed to take the largest baby home when Mrs. Laura is discharged from the hospital; the other two must remain until they weigh about 5 pounds. The rare births caused great jubilation among the hospital staff members who said the infants were the first triplets born in the hospital in 25 years.

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

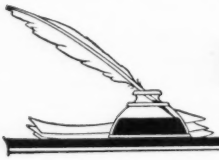
James E. MacDonald, 111 South Tenth Street, Philadelphia 7, Pennsylvania
Edmund L. Popp, 144 French Street, Buffalo 11, New York
Mrs. C. E. Youngblood, 300 Emerald Avenue, Johnstown, Pennsylvania
Mrs. D. E. Brouton, 1016 Jefferson Street, Fredonia, Kansas
Harry S. Halpern, DDS, 36th and Chestnut Streets, Philadelphia 4, Pennsylvania
Mrs. Lois Hudson, 350 Orange Street Southwest, Atlanta, Georgia
Marjorie R. Johnston, 5024 Washington Boulevard, St Louis 8, Missouri
Mrs. William Ziegler, Route 1, Box 332a, Arnold, Missouri
Mrs. Blanche Hutt, 2121 East 29th Street, Brooklyn 29, New York
Mrs. Howard Soots, Route 1, Gibsonville, North Carolina
R. B. Moore, DDS, Box 237, Allerton, Iowa
Kathryn Garson, 3256 Southwest Huber, Portland 19, Oregon
Mrs. Louvenia E. Lewis, 1822 Ruxton Avenue, Baltimore, Maryland
Bessie Young, P.O. Box 45, Fabius, New York

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ CXXXI

(See page 968 for questions)

1. True. (Sicher, Harry: Oral Anatomy, St. Louis, The C. V. Mosby Company, 1949, page 204)
2. (a), (b), (c), (d), (e), (f)—all. (Nelson, B. G.: Rational Timing of Orthodontic Treatment, JADA **47**:144 [August] 1953)
3. When an oxyphosphate cement adversely affects the appearance of the inlay. (Grossman, L. I.: Handbook of Dental Practice, Ed. 2, Philadelphia, Lippincott, 1952, page 360)
4. (a), (b), (c)—all. (Yudkoff, Irving: Mouth Preparation and Rest Design for Partial Dentures, New York J. of Dent. **23**:118 [March] 1953)
5. (b) 3 times. (Archer, W. H.: A Manual of Oral Surgery, Philadelphia, W. B. Saunders Company, 1952, page 124)
6. (a), (b), (c), (d),—all. Leatherman, G. H.: Self-Polymerizing Acrylic Resin as Filling Material, British Dent. J. **94**:121 [March 3] 1953)
7. Yes. (Accepted Dental Remedies, Ed. 19, American Dental Association, 1954, page 12)
8. True. (Auerbach, M. B.: Endodontia in Diagnosis and Treatment Planning, Journal of Dent. Med. **8**:4 [January] 1953)
9. (a) earlier. (Sarnat, B. G.; and Schour, Isaac: Oral and Facial Cancer, Chicago, The Year Book of Publishers, 1950, page 185)
10. No. (Phillips, R. W.: Amalgam—Its Properties and Manipulation, New York J. of Dent. **23**:107 [March] 1953)



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

TWO-LEVEL DENTISTRY

SLIGHTLY more than seven years ago (25 June 1948) a federal law was enacted that provides for fine or imprisonment of anyone who uses the mails or any instrumentality of interstate commerce to ship dentures made by a person other than a licensed dentist, except on authorization or prescription of a licensed dentist.

The intention of the law was to prevent:

1. The taking of impressions except by registered dentists.
2. The construction or supply of dentures by a person other than, or without the authority or prescription of, a person licensed to practice dentistry.
3. The construction or supplying of dentures from impressions or casts made by a person not licensed to practice dentistry.

The purpose of the law was to prohibit the mail-order denture business. Before the law was passed a lucrative business had been established by people who advertised that they could furnish do-it-yourself materials that would make it possible for people to take their own impressions, send them to a mail-order laboratory, and receive finished dentures. The kind of grotesque and harmful results are well known in every community.

Many of us had almost forgotten this nefarious mail-order denture business that was ended by federal law until the bootleg dental laboratory came into vigorous existence. The bootleg laboratory is not one that should be confused with the ethical commercial laboratories that design and fabricate dental appliances on the authorization or prescription of a licensed dentist. The bootleg laboratory may or may not be operated by a person with dental technical experience. The operator advertises

[1]House Bill No. 1118 of the Illinois State Legislature, introduced May 19, 1955, by Representative Powell.

denture repairs or denture replacements at a low rate. He may or may not have a licensed dentist as his collaborator.

In most states there are dental laws that prevent dental advertising to the public. Therefore, both the bootleg laboratory and the dentist who aids and abets it are in violation of state statutes.

To circumvent the statutes and the dental practice acts a bill was recently introduced in the Illinois General Assembly to license "*Public Denturists*" who were to be technicians with two years of some kind of vague and unspecified training. The bill provided:

"*Public Denturist*" means a person not licensed under the laws of the State of Illinois to practice medicine or to practice dentistry who engages in the practice in the State of Illinois of any or all of the following practices directly for the user, wearer, or prospective user or wearer, with right to offer and solicit, and without the necessity of a prescription or order of any person licensed to practice medicine or to practice dentistry:

1. The manufacture, construction, and supply of any removable prosthetic denture appliance, which will not become a stationary and permanent part of one's natural teeth, and to offer and solicit so to do;

2. The repair, replacement, reproduction, duplication, and supply of broken or missing parts of prosthetic removable denture appliances, and to offer and solicit so to do.[1]

The startling thing is that this bill passed the committee to which it was referred, but it failed passage in the House of Representatives due to the good sense of the members of the Legislature, to action by the dental societies and ethical laboratory associations, and the exposé by newspapers.

The introduction of such a bill in a state legislature means that there probably will be similar attempts in other states. Such legislation represents the two-level European system of dental practice. In such a system the licensed dentists perform operations in the mouth and the technician (or "*Public Denturist*") performs the more mechanical procedures in the mouth. With time, of course, he would arrogate more and more of dental operative procedures to himself.

The United States cannot afford such a degrading and dangerous method of supplying dental care. All our people are entitled to the best dental service from well-qualified and trained dentists and that is the objective toward which we should work.

Edward J. Ryan

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Denture in Dry Mouth

Q.—It seems that after thirty years of practice, I either have to return to school or come to you for help.

The case at hand is a full upper denture. I am using modeling compound and plaster of Paris. The impression was difficult to dislodge; it had to be pried apart to break the contact. The denture refused to stay. With a generous amount of postdam, I proceeded to reline, using contact, self-curing material—no improvement. The denture simply will not stay.

Have I stumbled on a dry mouth? Is there any way to tell a dry mouth from a normal condition, and is there a method to handle such conditions? I should appreciate whatever comment you can make in the matter, particularly concerning impression taking and keeping the denture from falling down.

Also, will you please give the steps in making jump (retention of teeth)? —G.B.P., Ohio.

A.—Do you squirt water from a water syringe above the periphery of your plaster-wash impressions before attempting to remove them?

I presume you have checked this denture to avoid muscle tension anywhere on its periphery.

I check the fit of such a denture using disclosing wax with about one-fourth vaseline added, to make sure that the denture is not riding on the hard medial area or on the rugae and also that the peripheral contact is correct. If so and it is a dry mouth devoid of saliva, you might try telling your patient what I told a man patient some twenty years ago before I knew anything about adhesive denture powders.

This maxilla had a smooth, glassy appearing membrane with no vascularity or moisture either, and I could not fit it with any degree of suction. I told the man that this failure was due to the condition present in his mouth, which was entirely beyond my control. But I told him that patients frequently come to the office wearing dentures that no longer bear any semblance to a proper fit, and they are apparently holding them in with their tongue, cheeks and lips, and that it was up to him to learn to either wear this denture as loose as it was or to go without teeth. This man came back in a year or two with his denture still as loose as when I made it, but he told me that it was perfectly satisfactory. He could eat everything with it, talk, laugh, and do everything that any denture wearer can.

A good way to jump a denture to new base material is to pour a cast into it and remove the teeth with the heat, one or two at a time, grind out the old denture material around the pins and anchor forms

of the posteriors, reset the teeth into their sockets with wax and proceed to flask, boil out, pack and process as with a new case.—V. C. SMEDLEY.

Child Fractures Incisors

My patient is 9 years old. He fell and broke both permanent incisors. The right incisor is broken so close to the pulp that I can see pink.

He experienced no pain and is getting along fine with zinc oxide and eugenol in celluloid crowns, except that the crowns are becoming discolored.

How long would you wait before placing permanent restorations?

I would like to place a three-quarter gold crown with porcelain facing, but my problem is how to place some medicant on the exposed pulp end of the tooth without getting cement on the area near the exposed pulp.

Would you outline your best restoration and treatment for such an injury? —J.L.T., Tennessee.

A.—The subjective symptoms of the fractured maxillary central incisors of your 9-year-old patient are favorable for the teeth remaining vital. The discoloration of which you speak, if it is of the type that indicates a hemorrhage into the dentine, is unfavorable.

Your present treatment is the best I know, and it should be continued until recession of the pulps from the fractured surfaces. It perhaps would be wise to cover the pink area in the right central with calcium hydroxide, and set the celluloid crown with zinc oxide and eugenol cement over that. Do not be in a hurry about making the permanent type of restoration.

Check frequently with roentgenograms and vitality tests. Roentgenograms you sent show nothing pathologic at root apices, but these apices should be watched for indication of pulp involvement.—G. R. WARNER.

Making Child's Denture

Q.—I have a daughter, 5½ years of age, who has a full complement of deciduous teeth. Her upper deciduous central incisors are about to be exfoliated, although the permanent centrals do not appear to be ready to erupt soon. It has been six months since her lower deciduous central incisors were exfoliated, and the permanent centrals have not yet appeared, although roentgenograms reveal that they will soon.

My daughter's occlusion is good and the maxillae have developed normally.

Esthetically, the missing lower teeth have not presented a problem, but I know that when the upper centrals are exfoliated, it will be a handicap to her, as she models clothes and does recitations for clubs and television.

My problem is to construct a removable appliance for her to wear on these particular occasions to improve her esthetic appearance. She has no spaces between her teeth. I believe I have read that removable appliances have been made for children who lose these teeth during the filming of a movie.

I would appreciate an early reply because she will have need for the appliance in the very near future.—H.J.O., Ohio.

A.—This objective can be accomplished simply by making a thin, palate-fitting, acrylic denture. It can be made to conform to the rugate pattern, and will usually stay in place without clasps or denture powder, but a little powder

could be used during her public performances.—V. C. SMEDLEY.

Treatment of Dry Sockets

I read in your column in ORAL HYGIENE[3] that you have never heard of guaiacol and glycerine being used as a remedy in the treatment of dry sockets.

I wish to state that this medication is effective. I have used guaiacol and glycerine in the treatment of dry sockets for the past thirteen years and found that it relieved pain in from five to eight minutes.

Once I was called to the hospital to see a patient who had a tooth removed and had been experiencing severe pain for two days. The physician had given her morphine without any relief. I irrigated the socket with saline, rubbed a cotton pellet soaked with this medication in the socket, and then placed in the socket a gauze dressing saturated with guaiacol and glycerine. The pain disappeared dramatically in five minutes.

The use of guaiacol and glycerine in the treatment of a dry socket was taught to us in exodontia, when we were seniors at Tufts College Dental School. This medication has been a godsend in relief of severe pain and suffering. I note also that this medication is included in *Prescription Writing and Materia Medica for Dentists* by L. R. Cipes, PhD, DDS.

The only objectionable feature to this medication is the pungent taste which it leaves in the mouth. This can be remedied by adding oil of anise.

The pain relieving nature of the medication far outweighs its taste disadvantage.

I read your ASK ORAL HYGIENE column regularly and find it both interesting and helpful, reflecting much experience and wisdom.—S. Scheinman, DMD, 1 Seventh Street, New Bedford, Massachusetts.

Please accept my warm thanks for your kind and courteous letter regarding the use of guaiacol in the treatment of dry sockets. Your experience is informative and convincing.—G. R. WARNER.

[3]Vincent's Infection, ASK ORAL HYGIENE in ORAL HYGIENE **45**:54 (January) 1955.

ARTERIOSCLEROSIS IS A GRADUAL PROCESS

HEART ATTACKS and apoplexy are the culmination of the gradual process of arteriosclerosis. The condition does not develop overnight. What a person is doing at the time of a vascular catastrophe has little to do with the attack itself. Contrary to popular belief, heart attacks do not occur on the golf course or tennis court more often than elsewhere. Only 2 per cent of the attacks occur during severe exertion. Almost half of the episodes occur during sleep. Those occurring under dramatic circumstances receive publicity, and the public, knowing little about the mechanism of the catastrophe, gets the wrong impression.—THEODORE G. KLUMPP, MD.

WHEN YOU CHANGE YOUR ADDRESS

WHEN YOU change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.

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Designed specifically as BRIDGE TEETH, Steele's New Hue teeth *minimize* the interproximal space.

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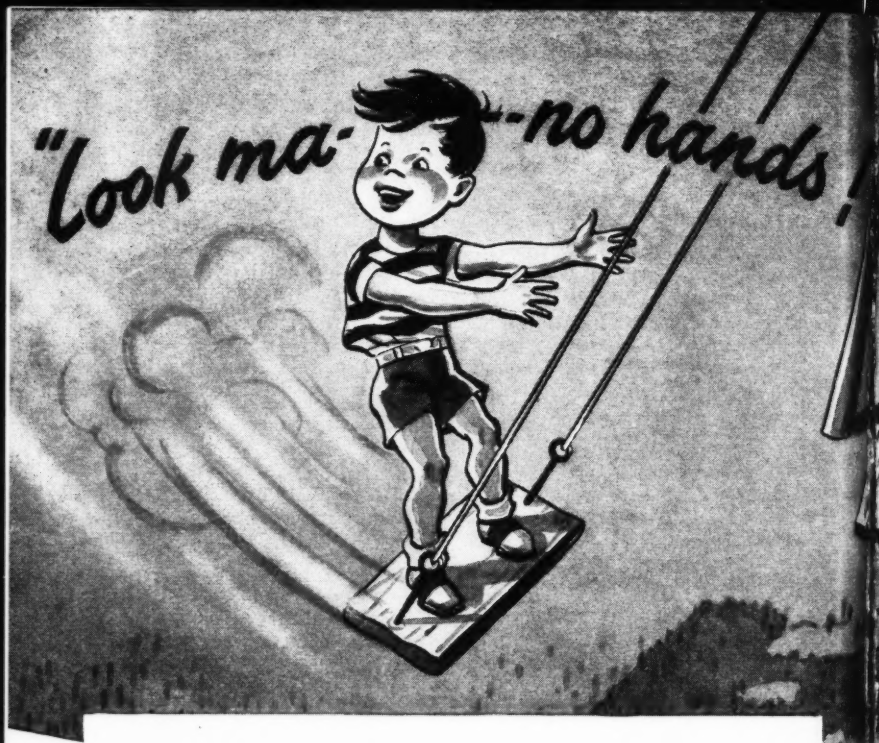

Junior has a long way to go before he becomes sufficiently expert, to swing "no hands" with safety.

And the average novice denture patient needs a lot of practice, too, before he becomes really "expert" in manipulating his new dentures. In the meantime, the use of Wernet's Powder can help a great deal in avoiding embarrassing "accidents"...can give the patient a much greater feeling of security, and thus encourage his patience and perseverance in mastering the new denture.

Wernet's Powder improves retention and stability—particularly in the presence of anatomical or psychologic difficulties; and increases the patient's comfort, by the soft, resilient cushion it provides.

WERNET DENTAL MFG. CO., INC. • JERSEY CITY 2, N. J.

Wernet's Powder

WERNET DENTAL LORE

AUGUST 1955

The irresistible advance of dental science over the centuries has been manifest in many countries, often under extremely adverse circumstances. For instance, back in 745 B.C., ancient Assyria was devastated by pestilence, and torn by a war in which Tiglath-pileser III seized the crown, and extended his conquest to all of Asia. Yet during this period, Assyrian physicians recorded their recognition of focal infection, and their recommendation that teeth be extracted to effect a cure.

* * *

One of the earliest prescriptions for massaging the gums with medication "until blood comes forth," as a treatment for loose or painful teeth, has been handed down to us on a clay tablet from Mesopotamia of the 7th century B.C. . . . a portent of modern periodontal therapy.

* * *

Dr. James Edmund Garretson of Philadelphia (1828-1895) was a man of strong convictions, who publicly deplored the lack by dentists of surgical knowledge and skill, and the indifference of surgeons to oral problems. He urged the development of "oral surgery" (a term which he coined) as a specialty in its own right — winning official recognition by being appointed "oral surgeon" to the hospital of the University of Pennsylvania in 1869. His pioneer book on "System of Oral Surgery" ran through five editions from 1869 to 1890.

* * *

Few realize that the western world probably first learned of the cultivation of sugar cane and the separation of sugar from India. Nearchus, the admiral of Alexander the Great, sailed down the Indus River in 327 B.C., and reported the Indian preparation of "a kind of honey growing in reeds or canes." Another product of the Indian flora is Gum karaya, derived from the Indian gum tree, and used in a purified state as the base of Wernet's Powder.

The Strides of Science

–from ancient runner

–from old time remedies . . . t

Folklore dentistry recommended eating the head of a spiny-back eel, or other oddities from acorns to Zulu cherries, as a sure cure for toothache.

Antiquated superstitions on dental therapy have yielded in this modern age to scientifically authenticated treatment—as with Poloris Poultice, formulated according to the sound principle of inducing analgesia by stimulating hyperemia.

In Poloris Poultice, the counterirritant action of capsicum relieves congestion, and thus alleviates pain while promoting tissue repair. Prompt relief is further assured by the quick-acting topical anesthetic, benzocaine.

Successfully employed for direct *local* action to relieve *local* dental pain, modern Poloris Poultice is free from the dangers often encountered with systemic depressant drugs.

Poloris Company, Inc., Jersey City 2, N. J.
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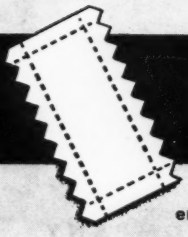

POLORIS

—for effective pain relief, with reparative stimulation, in emergency pain, pericementitis, dental abscess, erupting third molar, root canal therapy, gum irritation, and dental neuralgia.

City_____ Zone___ State_____

...to modern television

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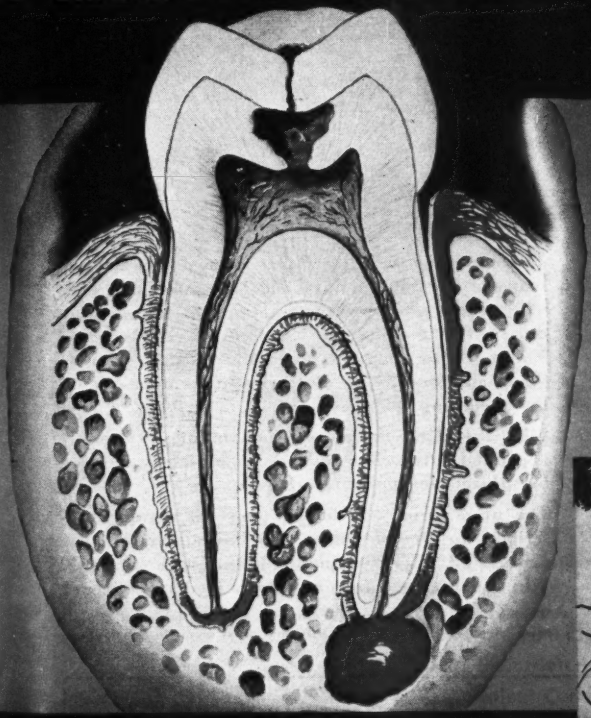

analgesia through hyperemia

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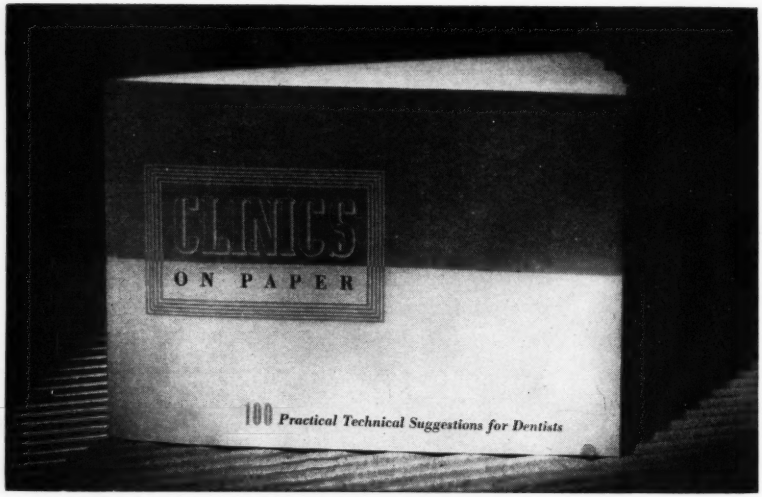

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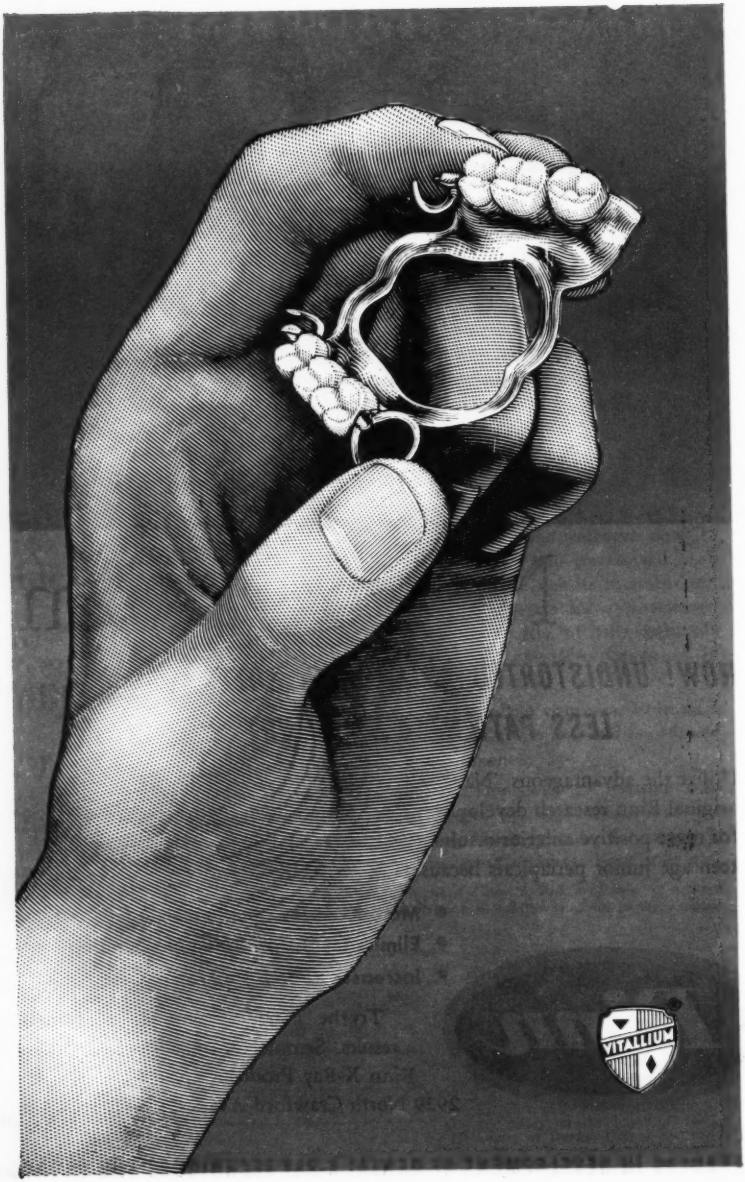
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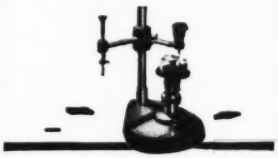

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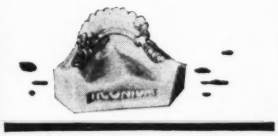

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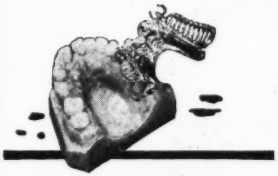

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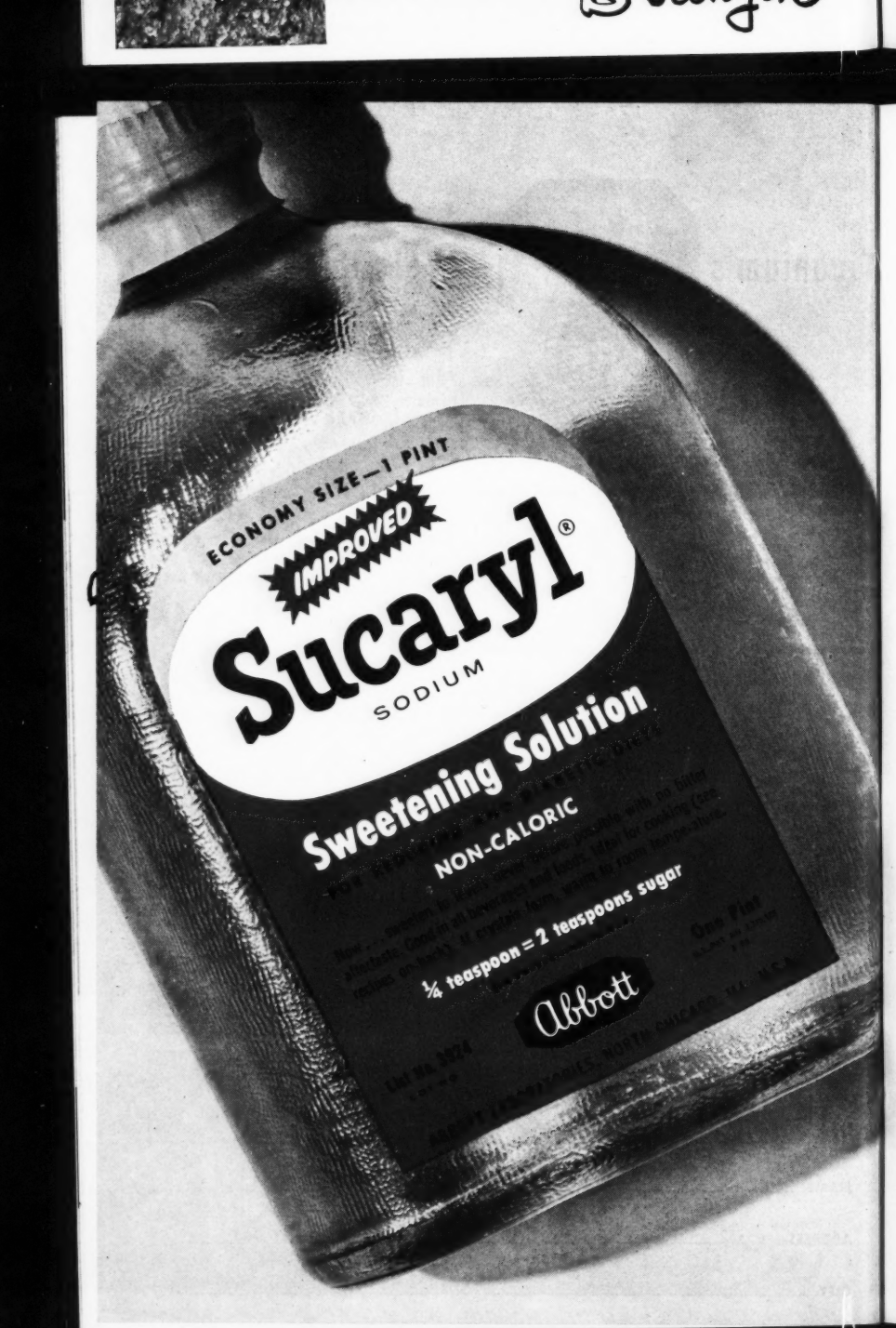
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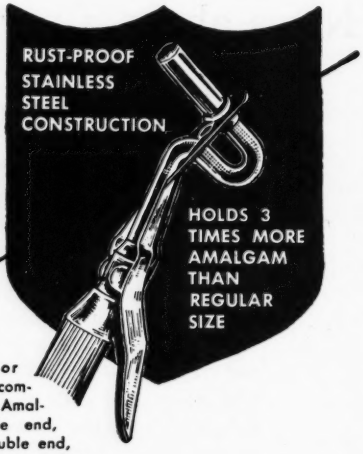

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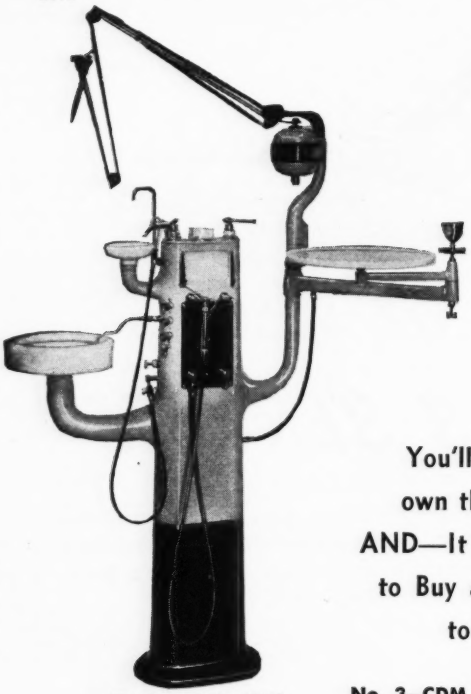

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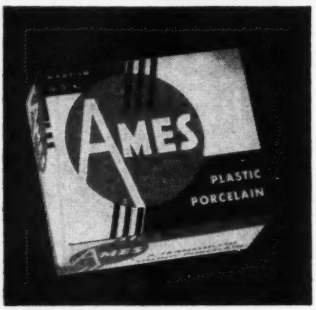

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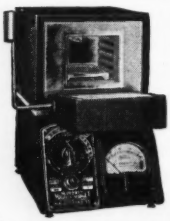

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Here at last is a practical approach to the problem of limiting and controlling nicotine and tar intake without reducing the pleasure of smoking.

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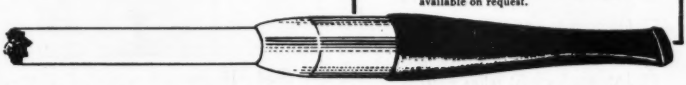
*Independent testing laboratory reports available on request.



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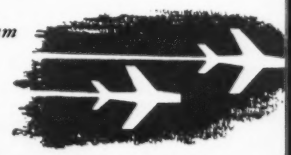

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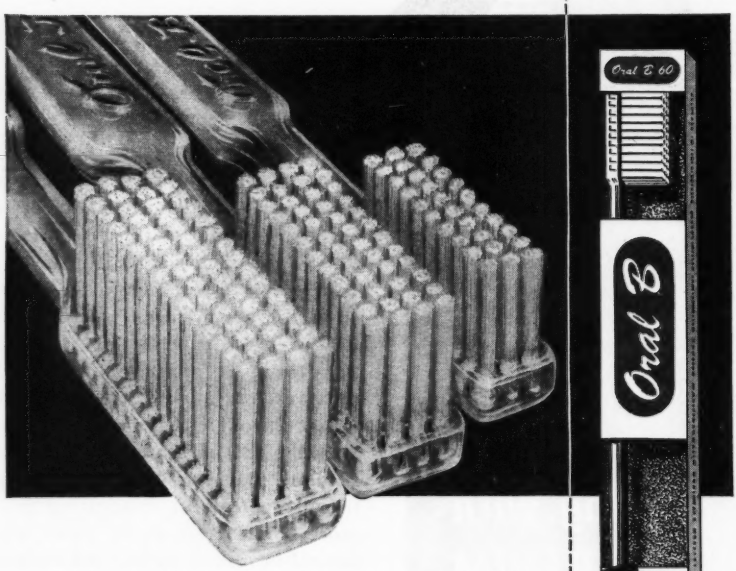
If you encourage gingival massage...



When a dentist recommends gingival massage, the patient usually has good intentions. But the problem of using another instrument for this purpose often results in neglect.

An Oral B toothbrush eliminates this difficulty. The gentle-action of 2500 softer smaller filaments performs a *double service*. The smooth tops clean teeth thoroughly without abrasion and massage gums effectively without injury.

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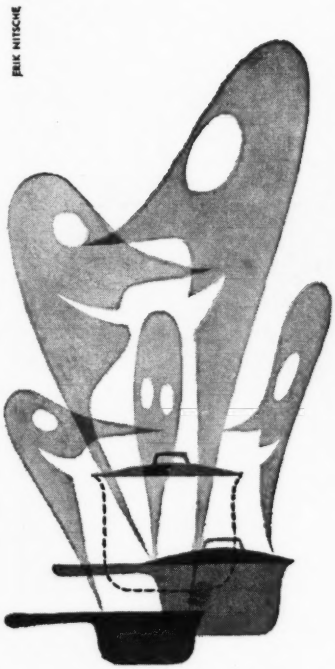

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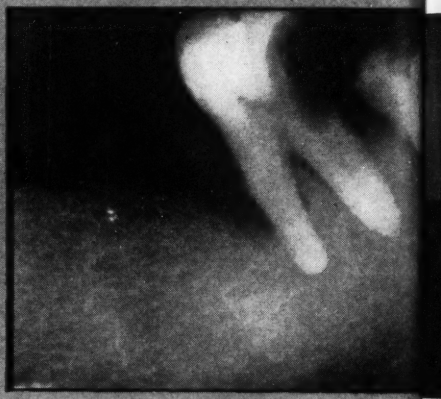

For adequate control of the infectious process, dental patients who are in need of antibiotic treatment may also require the concurrent administration of stress formulated vitamin therapy.

The availability of such an anti-infective as Tetracyn® (brand of tetracycline) has not altered the wise admonition to "treat the patient as well as the disease." The National Research Council[1] has emphasized that certain water-soluble vitamins (B complex and C) and vitamin K are involved in body defense mechanisms as well as in tissue repair and are required in increased amounts during the stress of febrile infections. Yet there is often a considerable reduction of these important nutritional elements in such patients.

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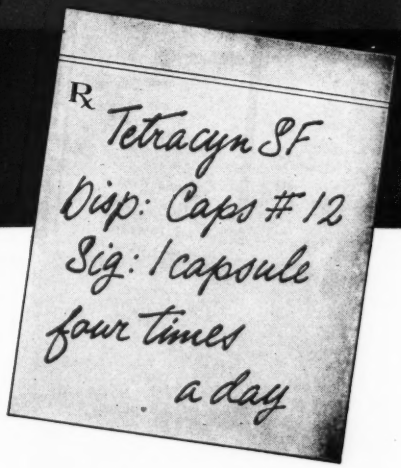
CAPSULES ORAL SUSPENSION

To fight the infection and stress fortify the patient with vitamins, write **SF*** with your prescription for Pfizer tetracycline



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Folic acid	1.5 mg.
Menadione (vitamin K analog)	2 mg.

1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition; Prepared in Collaboration with the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Washington, D. C., 1952.

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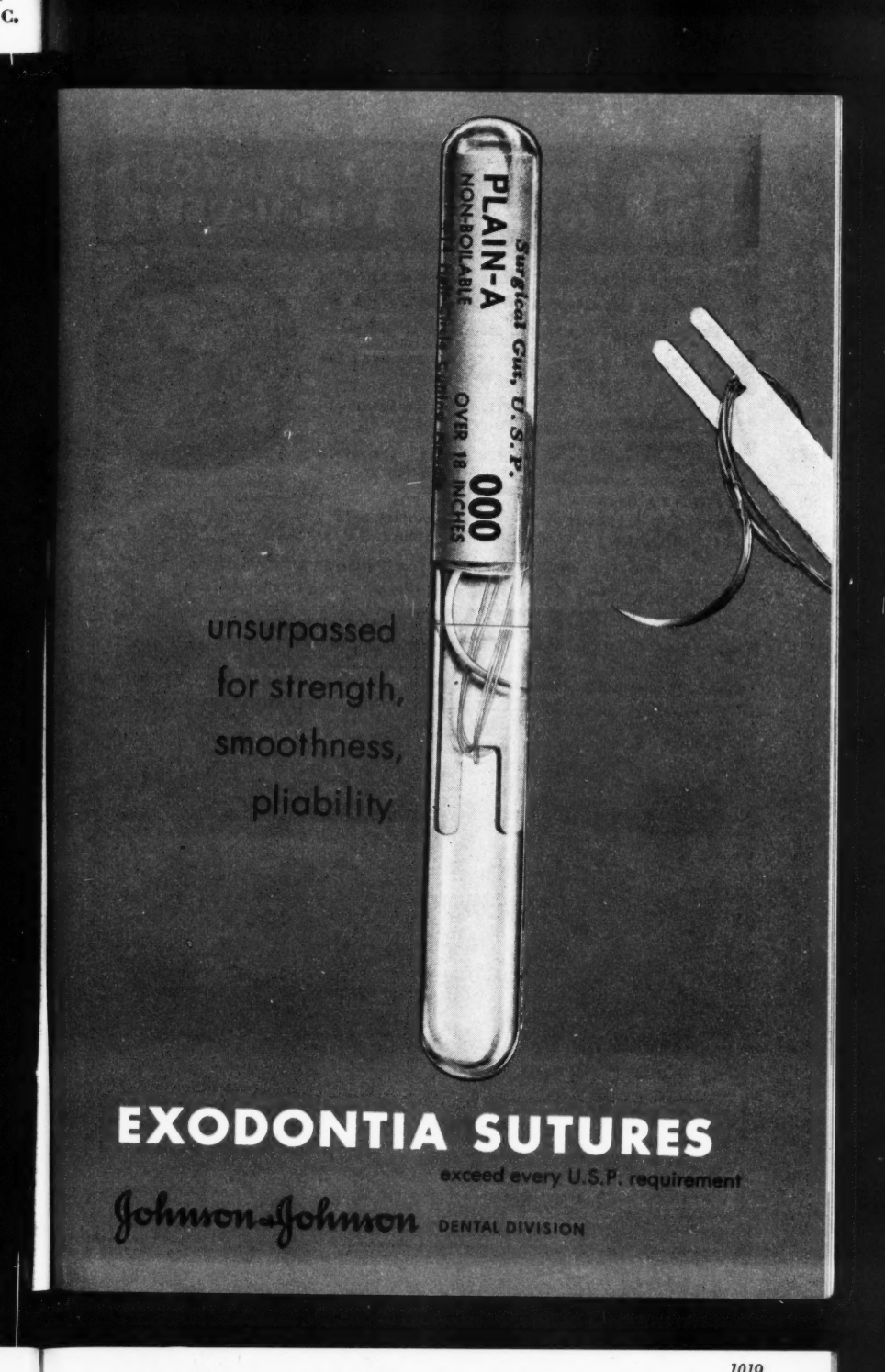
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CONTENTS

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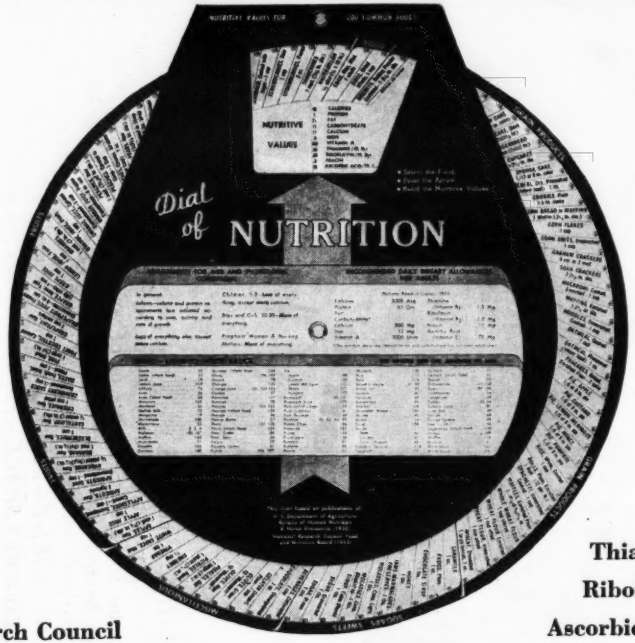

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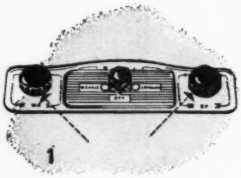

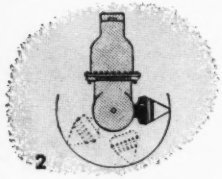

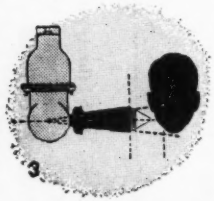

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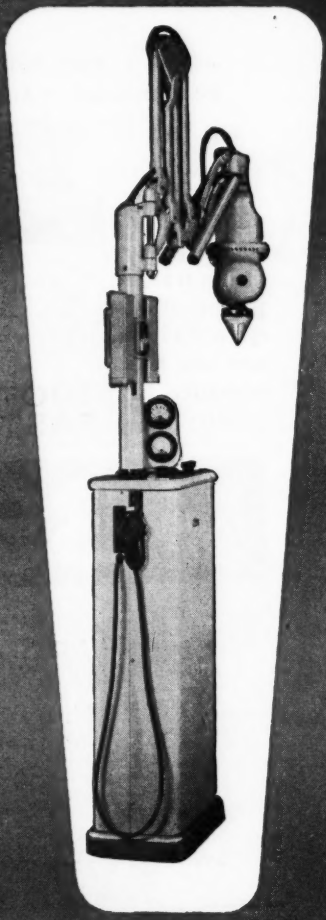

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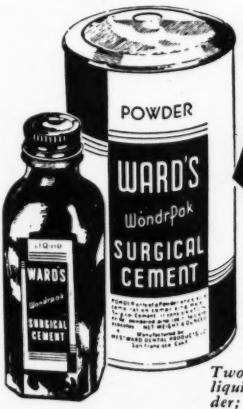

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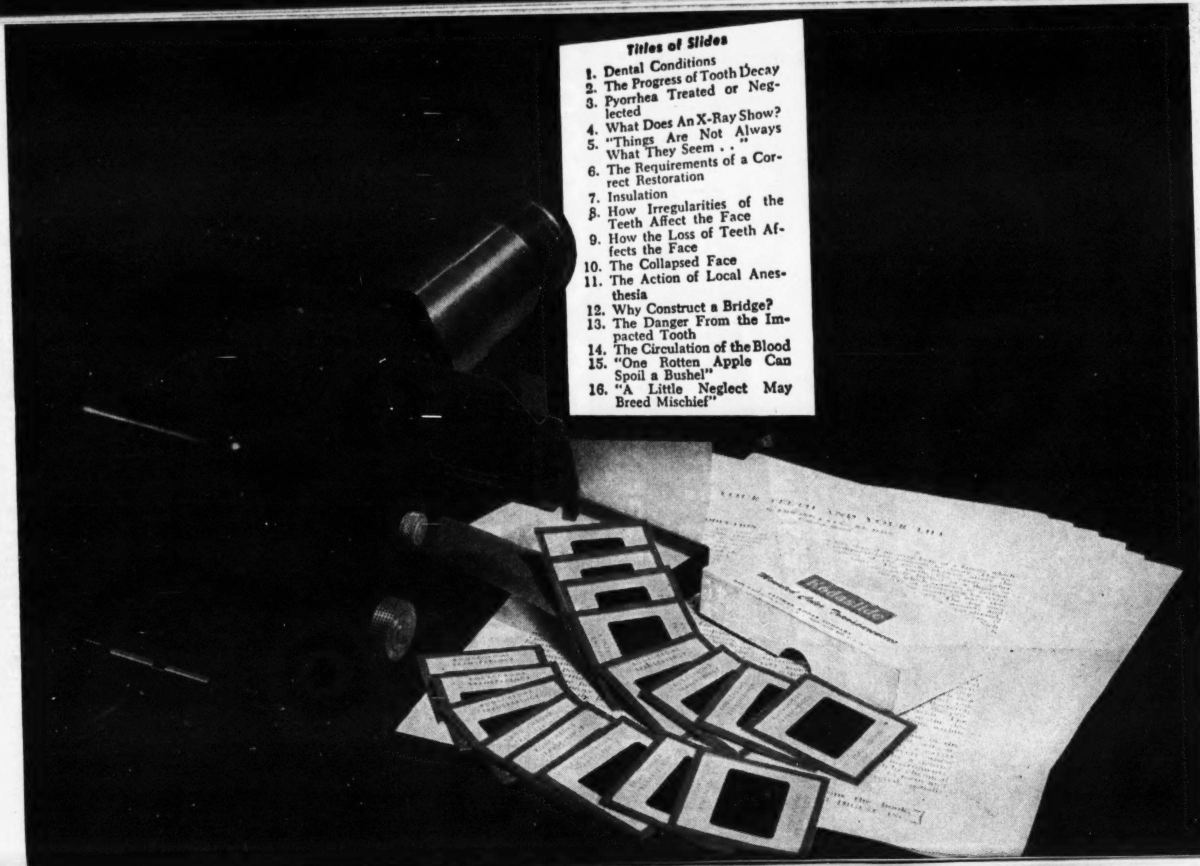

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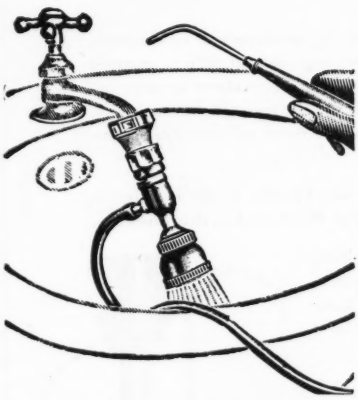

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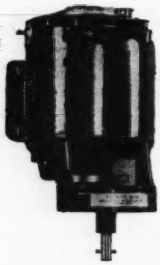

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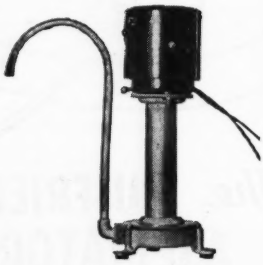

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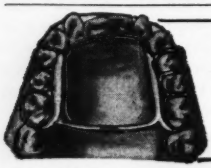

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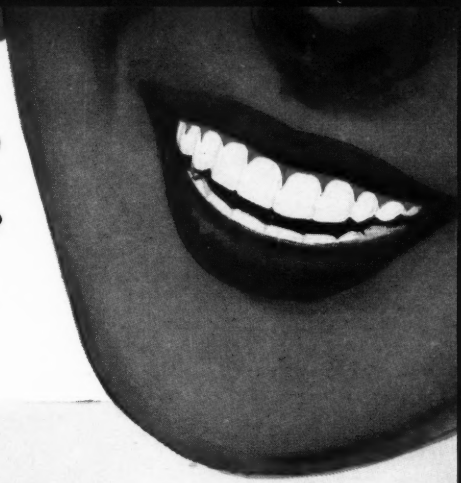

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Lower ( )

Patient.....

Dentures inserted (date).....

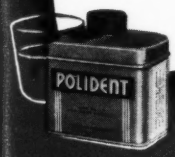
Reexamination (date).....

Abrasion.....

Discoloration.....

General Condition.....

Using Polident?.....



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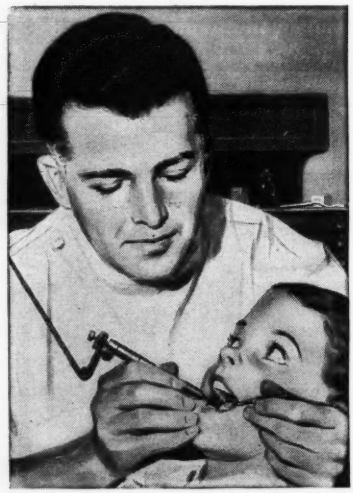
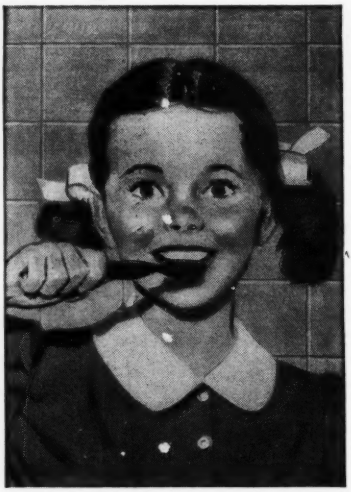


1 Your careful prophylaxis, treatment of cavities, and toothbrushing instruction.



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3 The use of a pleasant-tasting, cleansing dentifrice, such as IPANA.

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